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HOUSE OF REPRESENTATIVES
REPORT
102-130

VETERANS' HEALTH CARE AND RESEARCH AMENDMENTS OF 1991

JUNE 25, 1991.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. MONTGOMERY, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany H.R. 2280]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 2280) to amend title 38, United States Code, to extend and improve veterans' health care programs, having considered the same, reports favorably thereon with amendments, by unanimous vote, and recommends that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 3, line 3, strike out "for".

Page 4, line 21, strike out "1992" and insert in lieu thereof "1991."

Page 10, line 2, insert "the second place it appears" before the semicolon.

Page 19, beginning on line 8, strike out "adding at the end" and insert in lieu thereof "inserting after the item relating to section 5016".

Page 24, line 2, strike out "Programs" and insert in lieu thereof "Effective on October 1, 1991, programs".

INTRODUCTION

Many of the provisions in H.R. 2280 were included in H.R. 5740, as amended, which was reported by the Committee on October 12, 1990 and passed the House on October 15th of that year.

On April 10, 1991, the Subcommittee on Hospitals and Health Care held a hearing on a legislative proposal which subsequently became H.R. 2280. Testimony at this hearing illustrated the need

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for improvements in the delivery of health care and services to veterans. The Subcommittee heard testimony echoing views expressed at prior hearings that the opportunity to conduct research attracts many top clinicians to the VA. Additionally, witnesses testified that child care services at VA facilities are an incentive for many young health care personnel to seek VA employment. Testimony received at the April 10th hearing also revealed the need to improve and expand many existing health care programs.

Witnesses at the April 10th Subcommittee hearing were Dr. James Holsinger, Chief Medical Director, and Mr. Robert Coy, Deputy General Counsel, of the Department of Veterans Affairs. Testimony was also received from Dr. Thomas Detre, Chairman, VA Advisory Committee for Health Research Policy and President of the University of Pittsburgh Medical Center; Dr. Aram Chobanian, Dean of the Boston University School of Medicine; Dr. Richard Cohen, President of the American Federation of Clinical Research; Mr. Dennis Cullinan, Assistant Director, National Legislative Service, Veterans of Foreign Wars; Mr. Frank Buxton, Deputy Director of The American Legion's National Veterans Affairs & Rehabilitation Commission; Mr. Clif Dupree, Associate Legislative Director of the Paralyzed Veterans of America; Mr. David Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans; and, Mr. Paul Egan, Legislative Director of the Vietnam Veterans of America.

An April 24, 1991 hearing on the quality of VA care highlighted issues related to quality assurance. That hearing helped the Committee in shaping other provisions in the bill aimed at developing standards for, and tools to monitor, the quality of VA health care services. Testimony was received from the Honorable John Edward Porter, Member of Congress, Tenth District, Illinois; the Honorable Edward J. Derwinski, Secretary of Veterans Affairs; Dr. D. Earl Brown, Jr., former Associate Deputy Chief Medical Director of the VA; Dr. Dodd Wilson, Dean of the College of Medicine, University of Arkansas for Medical Sciences; Mr. Larry Rivers, Executive Director of the Veterans of Foreign Wars; Mr. John Hanson, Director of the National Veterans Affairs & Rehabilitation Commission of The American Legion; Mr. David Gorman, Assistant National Legislative Director for Medical Affairs of the Disabled American Veterans; and, Mr. Paul Egan, Legislative Director of the Vietnam Veterans of America.

On May 14, the Subcommittee on Hospitals and Health Care recommended H.R. 2280 to the full Committee and on May 29, the full Committee ordered H.R. 2280 reported to the House by a vote of 25 yeas to 0 nays.

Summary of the Reported Bill

The major provisions of H.R. 2280, as amended, would:

—Direct expansion of the homeless chronically mentally ill veterans program and certain specialized programs for treatment of Post-Traumatic Stress Disorder, subject to the appropriation of a specified level of funding for VA medical care above the President's budget request;

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—Expand veterans' access to medically needed outpatient dental treatment;

—Increase the limits on grants for home structural alterations;

—Direct the establishment of a pilot program of targeted medical research aimed at improving quality of clinical care, subject to the appropriation of a specified level of funding for VA medical and prosthetic research above the President's budget request;

—Require VA, in consultation with the Department of Health and Human Services, to prescribe standards to assure consistent performance by VA laboratories of valid and reliable laboratory procedures, and to report to the Veterans Affairs committees on those standards;

—Authorize VA to enter into arrangements with community institutions under which VA could procure, and the parties hold joint title to, and share the use of, jointly funded medical equipment; and

—Expand VA's authority to provide child care services.

Background and Discussion

TITLE I—HEALTH CARE BENEFITS

Contract Hospital Care for Veterans with Permanent and Total Service-Connected Disabilities

For many years, veterans who were rated permanently and totally disabled as a result of service-connected disabilities and who required care in private facilities under circumstances where VA care was not feasibly available had been eligible for VA sponsorship of the cost of that care. Such situations can arise in an emergency, specifically provided for under 38 USC 628, or on a prior authorization basis, as had been provided for under VA regulations. With the enactment of Public Law 94–581 in 1976, however, Congress set out in then section 601(4)(C) what it described as a listing of the only circumstances under which fee-basis and contract care might be provided under pre-authorized arrangements. Under that exclusive listing, now set out in section 603, coverage of the veteran rated permanently and totally disabled as a result of a service-connected disability was inadvertently omitted. Such veterans have among the highest claims to VA-sponsored care, and it is anomalous that they should be limited to VA coverage of care rendered in a medical emergency when other less disabled veterans may receive contract or fee-basis care on a pre-authorized basis under existing law.

Section 101 of the reported bill would provide for such coverage. The bill would, thus, reinstate an authority which VA had exercised for years under Departmental regulations; it does not represent an expansion of benefits as such but simply a clarification of Congressional intent. The Committee believes that this amendment will not result in a significant increase in the number of veterans receiving fee-basis and contract care.

Extension of Outpatient Dental Treatment

Under existing law, statutory limitations on providing outpatient dental care have resulted in the Department incurring costs which could be avoided. Although eligibility for outpatient dental treatment is limited, VA has authority to provide such treatment as a part of hospital care. Because of the limitations on outpatient dental treatment, patients who could have received such treatment on an outpatient basis have sometimes been hospitalized or been required to incur additional days of hospitalization to receive that treatment.

Section 102 of the reported bill would expand the circumstances under which VA may provide outpatient dental care to veterans. First, the bill would enable VA to provide limited outpatient dental services in preparation for hospital admission, typically in cases involving surgery and other procedures which could be compromised by dental infection. Current law authorizes VA to provide outpatient *medical* services needed to prepare for a patient's hospital admission, but a statutory limitation on the provision of outpatient dental care precludes the VA from furnishing medically required pre-admission dental procedures. Thus, under existing law, VA must hospitalize such patients to be able to perform limited dental work which is *medically* required.

The bill would also permit VA to provide outpatient dental treatment, where deemed medically essential, for veterans currently active in a VA treatment program. Although VA may provide *inpatient* dental care or outpatient dental services necessary to complete dental treatment begun incident to hospital care, the Department lacks authority to provide medically-needed outpatient dental treatment to patients suffering from dental problems which may compromise their medical health. The limitations of current law have forced VA to hospitalize such patients in some instances to have dental work done which could otherwise have been done on an ambulatory basis. It is anticipated that this section would result in a savings to the VA.

The bill would also require VA to obtain a second opinion in instances where the cost of proposed fee-basis dental care for a veteran would exceed $1,000. Current law requires a second opinion for procedures over $500. In keeping with the rising cost of medical and dental care, the bill would provide for a $1,000 ceiling and a periodic administrative adjustment of the limit, thereby allowing the VA to avoid costly reexaminations.

Extension of Annual Report on Furnishing Non-Service-Connected Health Care

In 1986, Congress enacted P.L. 99–272, the Consolidated Omnibus Budget Reconciliation Act of 1985. Provisions included in this law provided for reform of veterans' eligibility for VA medical care and authorized third party recovery from health care insurers for non-service-connected disabled veterans who obtain health care in Department facilities. A so-called "means test" was developed and implemented in response to budget reconciliation instructions to achieve cost savings.

Among its provisions, Public Law 99-272 required the Secretary to provide the Committees on Veterans Affairs of the Senate and the House of Representatives with a report on the effects of the eligibility reforms. The law required three annual reports due by February 1 of 1987, 1988, and 1989. Information required to be provided in these annual reports included the numbers of, characteristics of, and health care provided to, veterans (and amounts of payments made by them when appropriate) who are eligible for VA care by reason of the new income threshold criteria. It also included the numbers of, and health care furnished to, veterans in each of the other categories of eligibility, with breakdowns, in the case of such veterans with service-connected disabilities, for each percentile disability rating. The Committee believes that the report required under P. L. 99-272 contains important data about the VA medical system which is valuable to Committee deliberations. Section 103 of the reported bill would extend the reporting requirement through the end of fiscal year 1992.

Increase in Home Improvements and Structural Alterations Grant Program

The Home Improvement and Structural Alterations (HISA) grant program was originally enacted in 1976 under Public Law 94-581. There have not been any increases in the authorized amount of such grants since enactment. Under this authority (contained in section 617(a)(2) of title 38, United States Code), the VA is authorized to provide a one-time grant to help defray the cost of architectural modifications and structural alterations to the homes of disabled veterans. These improvements may be furnished as part of home health services only as necessary to assure continuation of treatment for the veterans' disability or to provide accessibility to the home or bathroom. Examples include the addition of wheelchair ramps, stairlifts, or widening the doorway to a bathroom to accommodate a wheelchair, all necessary alterations which would be essential in order for the veteran to reside at home.

Although the grant amounts provided under this authority have never been increased, the costs associated with construction and home modification have more than doubled in the past 14 years. Also, veterans in need of this assistance are often faced with both a catastrophic disability and prohibitive costs associated with making necessary lifestyle adaptations. In creating the grant benefit in 1976, congressional sponsors had the hospitalized veteran particularly in mind, and sought to avoid situations where a profoundly disabled veteran could not be discharged from the hospital because his or her home was not wheelchair accessible or otherwise able to accommodate the veteran's disabilities. VA has advised this Committee that its recent experience with this benefit indicates that the existing dollar limits have had a disproportionately harsh effect on the non-service-connected individual. The individual with non-service-connected disabilities, under existing law, has thus been expected routinely to bear more than half the cost of needed home alterations, a situation which threatens to create the very problem which this benefit was designed to overcome.

In order to keep pace with the inflationary costs of home improvements and to provide a level of assistance adjusted to the intended level provided in P.L. 94–581, section 104 of the reported bill would increase from $600 to $1,200 the limit on grants to non-service-connected disabled veterans and from $2,500 to $3,300 the limit on grants to veterans who require the grant for a service-connected condition or who have a service-connected condition rated at 50 percent or more.

In proposing revisions to the grant limits, the Committee notes that the Congress has substantially revised VA health care eligibility since 1976 when this grant program was instituted. Both the indigent non-service-connected veteran and the service-connected veteran are considered so-called "Category A" veterans for purposes of access to hospital care.

While the Committee has increased by $800 (to a maximum of $3,300) the dollar limit for the service-connected individual, the Committee has not found a doubling of the dollar limit to be needed. In that regard, the Committee notes that as interpreted by the VA, *the eligible veteran with a service-connected disability would actually have a $4,500* limit under the reported bill, in that the individual would be eligible for a grant of up to $3,300 in connection with improvements or alterations tied to the treatment of service-related conditions, and a separate "account" of up to $1,200 for home alterations for conditions of non-service origin.

Extension of Veterans Memorial Medical Center, Republic of the Philippines

It has been the policy of the United States that this nation has a moral obligation to provide care to those Filipino veterans who served in components of the U.S. Armed Services. This policy, which has been consistently renewed by the Congress, began in 1948 with enactment of legislation to construct the Veterans Memorial Medical Center (VMMC).

Section 105 of the reported bill would extend until September 30, 1992 the President's authority to enter into contracts with the VMMC for the care of these U. S. veterans in the Philippines.

Homeless Veterans Programs

Since 1987, VA has mounted initiatives across the country to reach out to homeless veterans, and particularly those afflicted with chronic mental illness. These efforts, sparked by Public Law 100–6, combine outreach by VA staff with VA treatment and placement in halfway houses and other therapeutic settings. Favorable evaluations of these pilot efforts, coupled with the enormity and complexity of the problems posed by homeless chronically mentally ill veterans, have led Congress to provide for expansion both of the HCMI program as well as a VA domiciliary care program for homeless veterans.

Hearings in the last session of Congress on provision of care to homeless veterans helped highlight the impact of these initiatives. These hearings helped as well to point up the need for additional VA staffing for these efforts in some communities and to recognize unmet needs in others.

The President's budget for fiscal year 1992 proposed $16.5 million for the HCMI program, and the same funding level for VA's domiciliary program for homeless veterans. That level provides an increase of $787 thousand, an amount aimed at keeping pace with inflation. In its March 11, 1991 report to the Committee on the Budget (pursuant to section 301 of the Congressional Budget Act of 1974), this Committee proposed additional funding of $3.25 million for the HCMI program. The Committee based its recommendation on its recognition of the needs of homeless veterans as well as the strengths of this particular program. Its recommendation was to expand by four the number of communities served by a VA HCMI program and to expand staffing at a number of HCMI sites with the greatest claim to such staffing support. These recommendations were based on findings that there remain major communities with substantial numbers of homeless veterans where such programs have not been established or in which the program's scope is modest in relation to demonstrated need. The Committee bill incorporates the same proposal, and authorizes appropriation of $3.25 million for fiscal year 1992 and such sums as necessary for subsequent fiscal years.

In its report, the Committee noted that while many VA programs assist the homeless veteran, the outreach component of the HCMI concept has been particularly successful because it tends to build on the capabilities and strengths of the local community. Section 106(b) of the Committee bill incorporates the same concept into a proposed pilot program. The Committee seeks to provide VA authority to conduct a modest pilot which would attempt to harness the energy which can come about from linking the efforts of the local community—whether local government or a nonprofit entity—with those of the Department of Veterans Affairs. As noted in our report to the Budget Committee, it may be possible to stimulate more effective provision of services to homeless veterans by encouraging cost-sharing between VA and the community.

The pilot proposed in section 106(b) would permit VA officials in at least one community to enter into an arrangement with a public or private entity under which VA, or VA in conjunction with such entity, would provide a range of services to homeless veterans with some need for medical treatment and rehabilitation. Those services would include a component to "reach out" to veterans in the community using vans or other means of transportation, another component to provide medical and rehabilitative services, and provision of transitional housing. Beyond sketching the outlines of such authority, the Committee bill does not seek to prescribe in detail the manner in which this "joint venture" shall be carried out. It does require, however, that there be an element of cost-sharing with the community institution providing on an in-kind or a reimbursable basis for at least 25 percent of the cost of services provided. In contrast to other VA programs targeted at the homeless, the pilot does not specify that beneficiaries are limited to those who suffer from chronic mental illness, though such individuals would not be precluded from participating in any such program established under this authority. It does, however, anticipate that veterans will be served under this initiative and that they will require medical and rehabilitative services.

The bill authorizes the appropriation of $300,000 for the program for fiscal year 1992, and such sums as may be necessary for subsequent fiscal years. While the reported bill does not specify a "sunset" date for this pilot program, the concept presupposes that it will not be of indefinite duration. The Committee anticipates, accordingly, that VA would operate such a program for up to three years, and would assess and evaluate its operation.

Limitations on Program Expansion

In the Committee's report to the Committee on the Budget on proposed levels of spending authority for veterans benefits and services for fiscal year 1992, it made recommendations based on budget hearings and a detailed analysis of the President's budget. The Committee's recommendations included increases for discretionary accounts within its jurisdiction of $661 million. The most substantial component of that proposed increase was in the veterans' medical care account where the Committee identified a pressing need for additional funding of some $436 million above the amount requested by the Administration.

In seeking that relatively modest increase, the Committee recognized that for fiscal year 1992 the President had recommended the largest budget ever proposed for veterans' programs. Similarly, the Administration's proposed medical care funding level, $13.287 billion, reflected a record level and an increase of 7.9 percent above the prior fiscal year. The Committee's views on the size of the proposed medical care account were tempered, however, by the realization that the nearly $1 billion increase ($976 million) in budget authority would largely be consumed by pay raises, inflation, and other uncontrollable cost increases.

While these data suggested that the fiscal year 1992 budget would at least constitute a "current services" budget, a detailed analysis of the Administration's medical care proposals, two days of budget hearings, and discussions with VA hospital administrators provided a more accurate, though gloomier picture.

The budget itself, while reflecting an increase, in fact achieves it in part through illusory "savings". For example, the budget excises $70 million and 1178 FTEE from the medical care account based on what amounts to a mandated "productivity" cut. The Administration budget would simply eliminate that level of hospital staffing and funding, basing those cuts on the notion that VA should make up the loss by "emphasizing" less costly ambulatory care. Since VA ambulatory care has been as hard hit as other aspects of VA's medical programs, such "emphasis" cannot conceivably absorb additional workload without new funding.

The budget also failed to account for a number of substantial, clearly identified costs. For example, it made no provision for the impact of section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), which attempted to provide State Medicaid programs with the same discounts for prescription drugs as negotiated by other purchasers. This law, which pegged those discounts to the "best price" in the market, has led manufacturers to increase their prices to VA. Tragically, with negotiating successes which have often made its prices the "best" in the market, VA has seen price

increases of some 40 percent in those procurements covered by the law. As a result, VA has already incurred substantial increases in pharmaceutical costs, and this vulnerability could result in additional unfunded costs estimated by the Department to be as high as $150 million in fiscal year 1992.

The VA faces other serious shortfalls as well. The Administration budget simply fails to provide sufficient funds to cover in full the cost of implementing recent pay legislation—for nurses as well as physicians and dentists. That legislation, Public Laws 101–366 and 102–40, was crafted to remedy serious recruitment and retention problems facing many VA facilities. The Administration budget, however, would fund only 62 percent of the CBO-estimated cost of the physician/dentist pay provisions—some $26 million short. Preliminary VA data on its experience in implementing nurse pay reform indicate that the amounts contained in the fiscal year 1992 budget request may cover less than half the actual cost.

These shortfalls, which make the fiscal year 1992 proposal a less than current services budget, must be seen in the context of a decade of underfunding. The Committee has documented this phenomenon in hearings in both the 100th and 101st Congresses. That underfunding has taken a severe toll on the infrastructure of the VA health care system, which struggled to maintain operating budgets during the late 1980's by desperately redirecting monies budgeted for equipment and maintenance to providing needed care for veterans. These policies have contributed to a literal erosion in VA health care, exemplified by an unfunded replacement medical equipment backlog approaching $1 billion. The failure to significantly reduce that backlog has critical implications for the quality of VA care.

Providing mandated care to a population which has become older and sicker by the year with a budget which has not increased in spending power has meant increasing delays in patients' access to care, bed closures, elimination of costly drugs from hospital formularies, and rationing of both routine and life-saving care. The pressures on the Department of Veterans Affairs to provide for veterans' needs in the face of virtual budget straightlining over a decade has been made more acute by expansions in eligibility for VA care during that period, congressional mandates for new medical programs and the establishment of new treatment facilities.

Section 107 of the reported bill would provide that VA may carry out provisions of the reported bill which call for expanding specialized programs—to treat Post-Traumatic Stress Disorder and to assist homeless veterans—only if the appropriation for fiscal year 1992 for the medical care account of the Veterans Health Administration is not less than $100 million greater than the amount which the President requested in his fiscal year 1992 budget for that account.

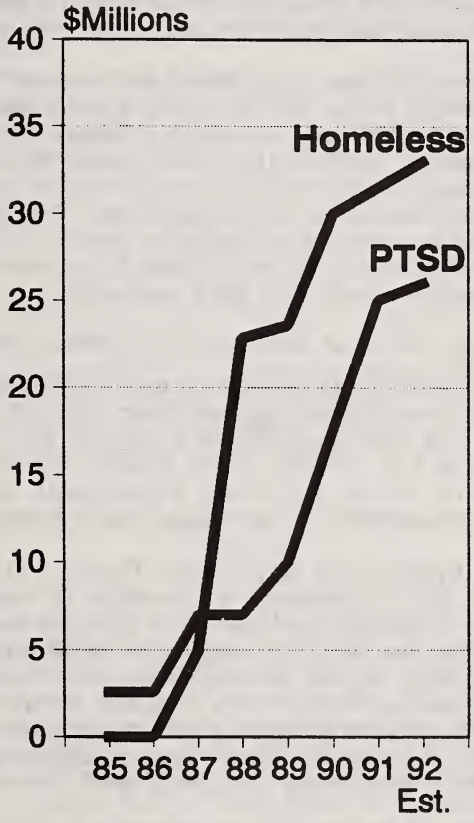
While the reported bill provides for expansions of VA programs for homeless veterans and specialized programs for treatment of PTSD, the Committee is sensitive to the dilemma that simply mandating program expansions, while needed, would come at the expense of ongoing VA care in a system already under severe strain. Furthermore, as the chart below illustrates, these particular specialized programs have had relatively significant increases in fund-

ing during a period when VA medical care systemwide saw an erosion in funding support. Thus, the Committee seeks to condition such expansions on Congress appropriating a substantial amount—at least $100 million—more in funding for the medical care account for fiscal year 1992 than the $13.287 million requested in the President's budget. Section 107 of the reported bill would establish that limitation in law. While an additional $100 million will not make up the shortfall we have identified in the President's budget, it would help establish the position that new or expanded programs, however meritorious, should not be established at the expense of providing ongoing care and maintaining the infrastructure needed to assure that that care meets the standards of good medical practice.

Department of Veterans Affairs

Health Care Funding

1985—1992



TITLE II—HEALTH CARE PERSONNEL

Licensure of Social Workers

Existing law does not require the licensure of social workers within the Veterans Health Administration (VHA). At present, however, 48 states, the District of Columbia, and Puerto Rico regulate the practice of social work through licensure, certification, or registration. The U.S. Public Health Service, as part of its licensure

and credentialing standards published in January 1986, established licensure as a basic requirement for social workers employed by that agency. Moreover, third party payers, such as Medicare, Medicaid, and some private insurers, require that the care for which payment is to be made be provided by individuals with appropriate credentials. CHAMPUS and the Federal Employees Health Benefits Program have used licensure as the basis for identifying minimal clinical practice standards for social workers participating in these programs.

In the Committee's view, qualifications for social workers in the Department should be no less stringent than those prevailing in the surrounding health care community. Section 201 of the reported bill would amend section 4105(a) of title 38 by requiring licensure, certification, or registration in order to be appointed to the position of social worker in the Department. This reflects the improving formal standards for admission to the practice of social work in the United States as well as the Department's own efforts to have the most qualified work force available.

Minimum Period of Service for Scholarship Recipients

The VA's historical difficulties with recruitment and retention of selected health care professionals has been well documented by national studies and testimony before Congress. In the last session, Congress enacted P.L. 101–366, a bill which revised the nurse pay structure within VA to assist the Department in its efforts to become more competitive in recruiting badly needed nursing personnel.

The Health Professional Scholarship Program (HPSP) was first authorized in 1980 to address a shortage of registered nurses through VA provision of scholarships to students pursuing nursing careers. Initially, the program required a minimum two year employment obligation to VA for every one year of scholarship support. The program was designed in response to two emerging problems that were projected to become increasingly serious: first, a national shortage of qualified health care professionals and second, VA's difficulty in competing effectively with other employers for nurses.

Subsequently, Public Law 100–322 expanded VA's authority under the Scholarship Program by allowing the Department to make awards to students in additional scarce health care disciplines, and to make awards to part-time students. The law also reduced the length of service obligation incurred by full-time scholarship recipients from a minimum of two years to a one year "payback" for each year of scholarship support received.

The changes to the Scholarship Program in P.L. 100–322 generally enhanced the Department's ability to attract and recruit health care personnel in shortage areas. Those amendments generally gave VA the flexibility to carefully choose how to gain the most benefit from the Department's considerable financial investment in the Scholarship Program ($52.6 million between 1982 and 1990). It has become apparent, however, that the one year minimum service requirement dramatically limits VA's ability to benefit from its investment. Coupled with VA's current policy of granting one year

awards to students in their last year of training, a one-year service obligation simply is not cost-effective. A typical graduate requires from 12 to 16 weeks of orientation and is rarely ready to assume full professional responsibilities for the first six months of duty.

Changing current law would allow VA to receive a fair return on its investment by ensuring that VA maintain the employment of scholarship recipients once they reach their full professional potential. Under current law, this is the point at which VA is most likely to lose them.

The Committee does not foresee any significant problems associated with enactment of this provision. The mandatory two-year service obligation in effect prior to P.L. 100–322 had proven to be effective in stabilizing staffing and lowering turnover rates. Moreover, based on historical trends, VA expects that the highly competitive Scholarship Program will continue to attract qualified candidates even if the service obligation is again raised to two years. In 1990, more than 1500 eligible applicants competed for 478 nursing scholarships; more than 350 students applied for 44 physical therapy scholarships; and more than 200 occupational therapy students vied for 41 available scholarships.

There is no cost associated with the enactment of this section. Increasing the "payback" obligation will benefit VA by allowing the Department to retain the services of scholarship recipients at a time when they are capable of assuming their full professional responsibilities.

Authority to Purchase Items of Nominal Value for Recruitment Purposes

The VA has long been at a disadvantage in the competition to recruit scarce health care personnel. Competing employers have successfully used advertising and promotion to lure employees to accept jobs at their facilities. Recognizing the need to actively campaign for employees, VA has elected to devote funds to advertise itself as an attractive employer to new graduates and other job applicants. VA now regularly places advertisements in major newspapers and journals of health care professional associations.

A relatively modest, but not insignificant element of promoting VA employment is distributing small items of nominal value at national and state meetings of professional associations, and at health care personnel job fairs throughout the country. These functions are attended by prospective employees as well as instructors and counselors. Many attendees may know little about VA. VA's participation in these events provides an excellent opportunity to enhance public perception and awareness of VA, and an avenue to expose groups of potential employees, advisors and counselors to a positive image of VA.

Examples of the promotional items successfully distributed in the past are pens and buttons. The items make reference to working for VA as a health care professional and include the toll-free number to call for employment information. The cost to VA is in the range of 50 cents to $1.50 per item. In fiscal year 1990, VA spent approximately $36,500 on direct marketing items for recruitment purposes.

Distribution of these items enhances VA name recognition for recipients of the promotional items, and gives potential recruits ready access to VA's toll-free phone number for information on employment opportunities, which has been especially helpful in attracting students.

Section 203 of the reported bill would allow the Secretary to expend funds for and distribute promotional items of nominal value to individuals as part of recruitment efforts to attract scarce health care personnel.

Recent opinions by VA's General Counsel and the Comptroller General have held that VA is not authorized to expend funds for promotional items. In light of the need for specific authority, and the potential benefit (in relation to the modest cost) of such items, the reported bill would authorize the Secretary to purchase these items. Such authority would ensure that VA has the flexibility to use promotional items of nominal value when necessary as part of an overall recruitment strategy.

TITLE III—ADMINISTRATIVE PROVISIONS

Authorization Requirement of New Medical Facilities

Section 301 of the reported bill would amend section 5004 of title 38, United States Code, to ensure that except for expenditures for advance planning and design, funds may only be appropriated or expended for major construction projects which have been authorized by law. It would also reduce the amount that could be appropriated or expended for leases of new medical facilities which have not been authorized by law to amounts less than $300,000 per annum. The intent of this provision is to guarantee that scarce funds will be utilized in the most effective manner. In the past, projects which have been low on the facility construction priority list have been funded prior to projects demonstrating a greater need. It also appears that long-term leases for outpatient clinics were entered into with little regard for other needed facility improvements. By restricting funds in this manner, it is the Committee's intent to provide funding for those facilities with the highest priority.

Submission of Reports of Geriatrics and Gerontology Advisory Committee

The Committee has long been concerned about the Department's short and long-range planning with respect to the growing number of elderly veterans in the United States and the increasing average age of those who need and are eligible for care in VA health care facilities. The projected increase in the elderly population of the United States is being experienced earlier in the veteran population than in the general population. The number of veterans over the age of 65 was 4.6 million in 1985 and is predicted to increase to 7.2 million by 1991 and to peak at 8.9 million veterans by 1999. In 1991, 60 percent of all males over the age of sixty-five will be veterans.

Against this background, the recent history in VA planning is troubling. The Committee notes the difficulties Congress has en-

countered in obtaining a comprehensive and feasible Department plan for meeting the extended care needs of veterans. The long-predicted need for medical and long-term care of the aging veteran population is already beginning to affect the VA.

In view of the Committee's inability to rely on the Department to provide it policy and planning guidance in this important area, the Committee must look to other sources. The VA's Geriatrics and Gerontology Advisory Committee has provided such guidance but its reports may not reach Congress, under existing law, for 90 days after the Secretary receives them. In fact, VA's submissions of the Advisory Committee's reports have seldom been timely.

Section 302 of the reported bill would amend subparagraph (C) of section 4101(f)(2) of title 38 to provide that reports issued by the VA's Geriatrics and Gerontology Advisory Committee will be submitted simultaneously to the Secretary and the appropriate Congressional committees.

Pilot Program of Research to Improve Clinical Care

The Administration budget for VA medical and prosthetic research for fiscal year 1992 would maintain funding at the current level of some $217 million, in spite of the fact that research and development is identified in budget documents as a Presidential priority. Significantly, a current level research budget for VA would effectively shrink VA's outstanding research program. The Administration itself states that a "straightlined" VA research budget would reduce the award rate for research proposals—that is, the likelihood that a research proposal *judged by peer review to be meritorious* would be funded—from 40 percent in fiscal year 1991 to only 25 percent in fiscal year 1992.

This Committee has heard testimony for many years on VA's research program and consistently found research to be a critical component of quality medical care. Committee budget hearings this year and testimony on this measure at an April 10, 1991 legislative hearing reaffirmed that point. The value of the VA research program far exceeds the acquisition of new knowledge. A vibrant VA research program is an important aspect of VA's efforts to recruit and hold top clinicians.

Significantly, VA research only recently underwent a careful, independent analysis by a "blue ribbon" advisory body—the Department of Veterans Affairs Advisory Committee for Health Research Policy. It conducted a year-long review of the VA research program at the Secretary's request and provided a report and recommendations in January 1991. To address the Secretary's charges, the Committee collected information about the VA's research program from VA Central Office staff, met with research leaders in the VA and the Department of Health & Human Services, conducted site visits at selected VA medical centers and solicited the views of a wide spectrum of national organizations concerned with VA research. In addition, public comments were received during the Advisory Committee's meetings. The Advisory Committee urged maintenance and enhancement of a mission encompassing teaching, research, and medical care. The Advisory Committee also found that the VA research program is generally appropriately balanced but

is inadequately funded. The panel endorsed the funding strategy VA employs of allocating research funds on the basis of the quality of the research proposed, but identified a need for the development of additional research directions. It found the overall quality of VA research to be exceptionally high, and on a par with NIH. Finally, in recommending that research funding be increased, the Advisory Committee proposed a $280 million budget for medical and prosthetic research for fiscal year 1992.

This Committee's report to the Budget Committee built on several of the "blue ribbon" panel's recommendations, and this Committee's proposal to the Budget Committee is reflected in the reported bill. While the Committee approves the budgetary goal set by the Secretary's panel, the Committee envisions this to be a goal toward which the Congress could build over a number of fiscal years. By way of an interim figure, the Committee recommended an overall increase of $43 million in research funding over the Administration budget. This funding level would provide both stability in ongoing research as well as the promise of sufficient growth to provide critical incentives for young clinician-researchers.

The reported bill would provide, accordingly, for a new research pilot program, the establishment of which would be conditioned on Congress appropriating at least $43 million more for VA medical and prosthetic research than the $216.8 million requested for that account in the Administration's budget for fiscal year 1992. The reported bill would call for VA to set aside $6 million of that $43 million for special initiatives in the areas targeted in the bill, all areas identified by the Advisory Committee. To maximize the impact of these monies, the reported bill would provide that a VA facility, to be eligible to compete for such funding, must have established an arrangement with an educational or similar institution under which that institution would agree to provide partial funding or in-kind support for the proposed research. The process of awarding "grants" to VA medical facilities from among competing proposals would take into account the extent of the contribution to VA clinical care which the proposed "sharing partner" would make.

The reported bill does not prescribe the mechanism or structures through which such sharing arrangements might be undertaken, and leaves it to the ingenuity of the respective facilities to develop proposed arrangements consistent with, and aimed at carrying out the purposes of, the bill. In joining forces with VA researchers, such sharing partners can, in the Committee's view, strengthen VA's clinical and research programs. Thus the Committee views the $6 million designated for fiscal year 1992 as an important investment which can yield dividends for VA research, clinical care, and education.

Standards of Performance in Department Laboratories

Private Clinical Laboratories.—The enactment of the Clinical Laboratory Improvement Amendments (CLIA) of 1988 was prompted by congressional concerns regarding deficiencies in then-existing law. Investigation and oversight had uncovered a number of very disturbing problems in laboratory practices in the private sector and in the enforcement of Federal standards governing those lab-

oratories. Among the findings were (1) a total absence of regulation for, or inadequate regulation of, thousands of non-Federal laboratories—including laboratories which operate in intrastate commerce only and laboratories in physicians' offices, ambulatory surgery centers, and other small entities; (2) an inadequate system for enforcing compliance with Federal laboratory standards; (3) limitations in the use of proficiency testing as a means of validating lab performance; and (4) an inadequate system for overseeing screening for cervical cancer.

CLIA conditions the solicitation or acceptance of materials for specific laboratory examinations or procedures upon issuance of a certificate for such specific studies from the Secretary of Health and Human Services. The issuance or renewal of a certificate is conditioned on the laboratory's meeting requirements set in the law. Among those requirements are (1) submission to the Secretary of an application containing information regarding the types and number of procedures performed, methods used, qualifications of the laboratory personnel as well as such other information as the Secretary may require; (2) an expression of assurance to the Secretary that the laboratory will be operated in accordance with standards to be issued by the Secretary; (3) agreement to permit inspections by the Secretary; and (4) agreement to make records available and submit such reports to the Secretary as the Secretary may require. CLIA directs the Secretary to set fees for the issuance and renewal of certificates. Such fees are to be sufficient to cover the general costs of the program, including the costs of accrediting bodies and compliance activities.

CLIA permits accreditation by an approved private agency to serve as a means of meeting the certification requirement. An approved accrediting agency must have adopted standards for accreditation that are equal to, or more stringent than, the standards issued by the Secretary under CLIA. In essence, CLIA calls for the establishment of standards for laboratories (1) to maintain a quality assurance and quality control program and meet requirements relating to proper collection, transportation, and storage of specimens and reporting of results; (2) regarding maintenance of records, equipment, and facilities; (3) to govern personnel qualifications; and (4) to govern qualifying under a proficiency testing program.

The Health Care Financing Administration (HCFA) has proposed regulations for the implementation of CLIA '88. These proposed regulations provoked over 60,000 responses. While most health care organizations and health care professionals recognize the need for improved standards, there has been widespread criticism that the proposed regulations in many instances are unreasonably stringent. Significantly, the explanatory materials associated with the proposed regulations state that they would cover "Federal hospital laboratories." 55 Fed. Reg. 20896 (May 21, 1990). The preamble to the proposed regulations specifically states that "laboratories subject to CLIA . . . include . . . Federal hospitals, such as military, Veterans Administration and Public Health Service hospitals . . ." 55 Fed. Reg. at 20900. The preamble also makes it clear that VA laboratories in non-hospital settings would be subject to the regulations.

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Quality Assurance of Laboratories in the Veterans Health Administration.—Unlike private laboratories, the Department of Veterans Affairs is no newcomer to concern with laboratory quality. The VA operates more than 840 laboratories in its medical care system. That system includes 209 inpatient hospital and outpatient clinic laboratories, 188 limited special function laboratories, 233 ambulatory care laboratories, 126 nursing home laboratories, 52 nuclear medicine and 35 domiciliary labs. The VA also performs many bedside tests and tests at satellite testing facilities.

Currently, the VA operates a very stringent quality assurance program for its laboratories. VA laboratories undergo rigorous scrutiny from several widely-recognized independent bodies including the College of American Pathologists, the Joint Commission on Accreditation of Healthcare Organizations, the Armed Forces Institute of Pathology, and the American Society of Clinical Pathologists.

The College of American Pathologists (CAP) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) have conducted accreditation inspections of VA laboratories since 1970. The primary objective of these accrediting agencies is to improve the quality of clinical laboratory services through peer review and education. Under the CAP accreditation program, for example, each VA clinical laboratory is required to undergo an onsite inspection every two years and must perform a self-examination in the interim year. CAP also provides a comprehensive proficiency testing program on a quarterly basis. CAP review also provides an educational process which updates the quality of lab service and maximizes the accuracy of lab results. The CAP accreditation process has also fostered an exchange of programs and clinical techniques which promote higher quality standards. It is noteworthy that several current CAP standards originated in the VA. Many of the VA's own surgical pathology quality assurance standards have been incorporated by CAP into its overall requirements for accreditation.

In another facet of external review, the Armed Forces Institute of Pathology (AFIP) carries out a number of quality assurance programs for VA. It has done so since 1948. These programs provide quarterly, comprehensive peer review of surgical pathology and autopsies for each laboratory. By agreement, VA sends a representative sample of specimens which have already been diagnosed to AFIP for a second opinion peer review. In addition, the AFIP provides a quarterly examination of VA surgical pathologists' skills through a Histopathology Quality Assessment Program. The AFIP also provides consultation services to the VA; it does so by providing a second opinion for difficult surgical and autopsy cases.

As another quality control, the Department has arranged with the American Society of Clinical Pathologists (ASCP) to measure the proficiency of each *individual* VAMC pathologist in surgical pathology and cytopathology. The program provides 20 exercises a year and the ASCP sends proficiency results for each pathologist to VA Central Office (VACO). VACO monitors the errors and correlates these with the error rate from the individual VAMC's for surgical pathology and cytology.

In addition to these external reviews, the VA has implemented several internal quality assurance programs to augment the standard requirements of the accrediting organizations. An example is an internal quality assurance program for cytology and surgical pathology established in 1987. This program mandates, on a quarterly basis, a second review of ten percent of all surgical pathology and cytology cases diagnosed at each VA medical center. The mechanism for selecting cases for review ensures representation of those specimens most likely to pose diagnostic problems for VA medical centers, i.e. tumors or cases in which the diagnosis may affect the patient's ultimate treatment. The Department also recognizes that limitations of staff size at smaller hospitals place sole-practitioner pathologists at greater risk for diagnostic error than pathologists who are part of a team. To limit this risk, the VA program mandates that a documented, signed second opinion be obtained promptly on all malignant neoplasms and on at least 50 percent of all surgical pathology accessions in VA medical centers with only one pathologist.

Another significant internally mandated policy is one where the pathologist must notify *in person* the patient's physician of every new case of malignancy. This is intended to avoid any lapse in communication between the time that a diagnosis of the malignancy is made, and to assure that the patient's attending physician has been notified. The policies are enforced at the level of the VAMC and compliance with the policies is monitored quarterly by VACO Pathology Service, and reviewed independently by the CAP, JCAHO, and VA's Inspector General.

The Committee finds noteworthy the fact that JCAHO findings for all VA facilities surveyed from 1988–1990 showed that clinical laboratory services consistently scored a 1 or 2, which are the best JCAHO scores, indicating substantial or significant compliance with laboratory standards. In addition, laboratory scores are the most consistently high scores of any elements JCAHO reviewed.

Moreover, JCAHO survey data for 1990, the most recent year in which VA facilities were surveyed, showed that in the area of monitoring and evaluating pathology and medical laboratory services, VA had a substantial or significant compliance rate of 100 percent and an overall compliance rate for all other laboratories of 86 percent.

The Inapplicability of CLIA to the VA.—This Committee and the Department of Veterans Affairs itself have long placed a high priority on the quality of care provided patients in VA's health care system. That priority has reflected itself not simply in wide-ranging policies and standards to assure quality but in the establishment of a network of internal and external review mechanisms and bodies to monitor compliance with those policies and standards. As recently as the 99th and 100th Congresses, this Committee and its counterpart in the Senate authored legislation and worked to provide resources to establish and expand improved quality assurance programs and to expand the quality assurance activities of the Medical Inspector and the Office of Inspector General.

The VA's laboratory medicine and pathology program operates under rigorous standards and review requirements. The College of American Pathologists (CAP), which inspects and accredits some

4000 laboratories in the United States, has awarded accreditation to all VA's clinical laboratories.

As previously stated, the intent of the amendments made by CLIA '88 was to create new, uniform Federal standards under which unregulated or poorly regulated laboratories conducting tests on human specimens would operate. Most health care organizations and health care professionals agree that there must be standards by which labs should operate, but that these standards should be flexible enough to allow for both differences in health care delivery systems as well as pre-existing quality assurance programs.

CLIA '88 recognizes this need for flexibility by expressly stating that the standards for recognized accrediting organizations need not be identical to those set by HCFA but rather must be "equal to or more stringent than" those set by HCFA. The statute would treat states in the same manner by providing for an exemption for clinical laboratories in those states whose own standards are equal to or more stringent than those set by HCFA.

Section 304 of the reported bill would require VA to prescribe standards for its medical laboratories to assure consistent performance of valid, reliable laboratory examinations and procedures, and to consult with the Secretary of Health and Human Services in the development of such standards. The section would also require the Secretary of Veterans Affairs to report to the Veterans Affairs Committees of the Congress on the standards it prescribes. The provision would require that that report include a description of the differences, if any,—and an explanation of the basis for such differences—between VA's standards and the long-awaited standards which the Secretary of Health and Human Services is required to promulgate to implement CLIA.

While some of the language of CLIA can be read broadly, its sponsors had a clear target in focus, physician office laboratories (particularly cytology "mills") and similar unregulated or inadequately regulated laboratories. The amendments are best understood from the vantage point of congressional concerns with laboratory practices in the private sector where substantial changes had taken place in the more than 20 years since Congress enacted CLIA '67. As noted in the pertinent House committee report, "The clinical laboratory industry was then composed predominantly of small, nonprofit organizations. Today, large national corporations play a major role in an increasingly for-profit arena. In addition, new testing sites, particularly physician office laboratories, ambulatory surgical centers and health maintenance organizations, have proliferated." Committee on Energy & Commerce Subcommittee on Health and the Environment, House Report 100–899, p.11–12. Federal regulation over this scattered array was found to be deficient. In contrast, *the legislative record associated with CLIA's enactment makes no reference to VA laboratories* or to any deficiency in the performance of VA laboratories. As noted above, *the notion that VA laboratories would be subject to HHS regulation was expressed for the first time in proposed rulemaking by which the Department of Health and Human Services (HHS) sought to implement CLIA '88.* Subjecting the operations of one Federal department to regulation by another, however, raises important jurisdictional issues and is

not a step to be taken without a very clear basis in law. In view of the problems Congress sought to remedy, the Committee finds no basis for the view that Congress sought to have HHS regulate the VA.

Like the 1988 amendments, CLIA '67 applied to "persons" and "laboratories" (but only those operating in interstate commerce). CLIA '67 was construed to govern non-Federal entities only. CLIA '88 merely expanded the statute's coverage of non-Federal "persons" and "laboratories" operating in interstate commerce to all non-Federal "persons" and "laboratories." The only provision of the law which refers to Federal entities is new section 353(o), which authorizes the Secretary of Health and Human Services "pursuant to agreement, [to] use the services or facilities of *any federal* or State or local public agency" (emphasis added) to carry out the Secretary's responsibilities under the law. It is entirely plausible to read the amendments as authorizing HHS to enter into an agreement with VA whereby VA's expertise might be used in enforcing CLIA provisions. In any case, the draftsmen of CLIA were clearly sensitive to the importance of references to Federal, State, and local government, where provisions of law affected those entities. The Committee notes that the amendments make provision for a specific exemption from CLIA for clinical laboratories "in a *State* [which] enacts laws" (emphasis added) creating requirements equal to or more stringent than those under CLIA. Had Congress intended CLIA to reach *Federal* clinical laboratories, it would surely have expanded the State exemption provision to reach the parallel situation where a Federal Department promulgates regulations creating requirements equal to or more stringent than those under CLIA.

Similarly, Congress' imposition of a system which calls for HHS to charge fees to laboratories for certification illustrates that the sole focus and only reasonable reading of this legislation is regulation of private sector laboratories. The position of the House Committee on Energy and Commerce illustrates the point: "Given rising federal expenditures for health care and the scarcity of federal money to carry out enforcement activities, the Committee has determined that the costs of such regulation should be borne by laboratories." House Report 100–899, p. 37. That Committee acknowledged that such costs would ultimately be passed on to consumers. Were CLIA to govern VA, of course, that Department would be subject to fees for each of its laboratories. The Congressional Budget Office, however, specifically found that *"[n]o costs to the federal government would result;* the fees charged would fund the costs of the regulation." House Report 100–899, p. 21. If one reads CLIA expansively to sweep Federal laboratories within its scope, however, one must also conclude, for example, that one Federal Department may take a sister Department to court to review the imposition of sanctions under CLIA, under the judicial review provisions of section 353(k). Congress plainly did not intend that courts resolve disputes between VA and HHS. Just as plainly, it did not intend CLIA to apply to VA.

To the contrary, at the time CLIA was enacted Congress had already directed the VA on a systemwide basis to establish a comprehensive quality assurance program (section 204 of Public Law 99–166) in carrying out its primary function of providing a "complete

medical and hospital service." 38 U.S.C. sec. 4101(a). Pursuant to this mandate, VA had already developed standards and quality assurance mechanisms governing its clinical laboratories. There is no evidence, and no reason to believe, that Congress sought to modify its earlier mandate to VA, or VA's implementation of that mandate as regards the standards, or quality assurance mechanisms, governing its laboratories.

While this Committee rejects the HHS position which would grant that Department authority to inspect, monitor, and oversee VA laboratories, the Committee supports the view that VA laboratory standards should be comparable to or exceed those adopted under CLIA as a national norm. The Committee believes that VA would welcome the opportunity to demonstrate that its own standards meet or exceed those which the Secretary ultimately implements for private laboratories. In fact, by virtue of the requirements CLIA imposes upon accrediting agencies, for VA laboratories to continue to attain accreditation status after CLIA's standards are established, the Committee expects that those laboratories will necessarily have to meet or exceed those standards.

The Committee anticipates that the final HHS standards will differ in many respects from those set forth in proposed regulations, which provoked such voluminous public comment. In setting its target date for VA to prescribe its own standards, the Committee believes it has provided sufficient time for HHS to develop and publish final regulations, or at least to have sufficiently completed that work to be able to share its plans with the VA. Thus, the Committee does not view the possibility that HHS standards may not be final for some time as fatal to the design of this measure. In that connection, this Committee also believes that VA's years of working experience with operating its own laboratories under rigorous external review and its experience in developing its own internal quality assurance standards makes VA a valuable model for the Secretary of Health and Human Services to study in formulating CLIA standards. It is ironic and regrettable that the Committees which held hearings on this topic and subsequently authored CLIA '88 were apparently unaware of VA's experience in laboratory standard-setting, and did not invite testimony from the Department on this subject.

Acquisition of Real Property

Section 305 of the reported bill would remove a restriction now in the law which precludes the VA from acquiring and using real property, or accepting donated real property, before obtaining Department of Justice approval of the title.

Under existing law, before VA can expend funds to acquire real property, or accept a donation of real property, the Attorney General must determine the sufficiency of the title. The authority to examine title has been delegated to other Federal departments and agencies in several instances, but not to the VA, which must submit all title documents to the Justice Department for approval, slowing the acquisition process. Under section 305, VA would continue to seek Justice Department approval of title, but would be permitted to expend appropriated funds to acquire and use proper-

ty, or accept donations of property, pending final Justice Department approval.

This provision would also permit the Secretary to determine that a less than fee simple interest in property might satisfy VA's needs and be sufficient for the purpose of an impending VA project. In some instances, VA may not be able to acquire a fee interest in property on which it desires to construct a facility. With this provision, the Secretary could determine that a very long term lease, for example, one for 99 years, would provide the VA with sufficient interest in the property in order to build a permanent facility.

The Committee believes this authority will enhance VA's ability to acquire property necessary to serve the needs of veterans.

Research Corporations

In section 204 of Public Law 100–322, Congress granted VA specific authority to establish nonprofit corporations at any VA medical center to "provide a flexible funding mechanism for the conduct of approved research at the medical center." 38 U.S.C. section 4161(a). The statute specified that the corporations "shall be established solely to facilitate research as described in section 4101(c)(1) of this title in conjunction with the applicable Veterans' Administration medical center." 38 U.S.C. section 4162.

In establishing this authority, Congress provided in section 4161(b) that "[i]f by the end of the three-year period beginning on the date of the establishment of a corporation under this subchapter the corporation is not recognized as an entity the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, the Administrator shall dissolve the corporation."

VA survey data compiled on December 1, 1990, shows that IRS had granted definitive tax-exempt status to only 14 of the then 54 corporations which had applied for such status. Many of these applications have remained in a "pending" status for more than a year. There is evidence that considerations other than workload have contributed to the months of delay. Several IRS regional offices have referred VA research corporation applications "to Washington" for review at the national level based apparently on objections to granting section 501(c)(3) status to entities which receive some funding from pharmaceutical companies.

In Public Law 100–322, however, Congress specifically authorized VA research corporations to accept gifts from public and private entities. The legislative history of this provision demonstrates that Congress was aware that pharmaceutical companies were an important source of funding support for VA research, and that these corporations would continue to seek such support, where consistent with the VA research mission. Congress tacitly approved pharmaceutical company funding of VA research, as long as that research met VA mission, quality and human subject guidelines.

Under section 4164, no research corporation may accept funds from any source unless those funds are used for *VA-approved* research. Under VA procedures, any research to be carried out under VA auspices, including research funded through a VA research corporation, must win the approval of the VA medical center's re-

search and development committee. That committee must determine that the research project supports VA's patient care mission.

As noted by the General Accounting Office in a 1986 report, "VA Drug Company Sponsored Research at VA Medical Facilities", pharmaceutical company research support generally involves testing of new drugs which could presently or ultimately benefit VA patients as well as the VA's ongoing research and development program. GAO found it reasonable for VA to conduct such research under its research mandate.

This Committee sees no inconsistency between a VA research corporation's acceptance of funds from a profit-making entity to conduct efficacy testing of a new drug—where VA has determined that such testing furthers the VA research mission—and that corporation's holding tax-exempt status. Beyond its failure to act timely on VA research corporations' applications for tax-exempt status, the position of the Internal Revenue Service is unclear. VA Secretary Derwinski's effort in a May 23, 1990 letter to the Commissioner of the Internal Revenue Service to elicit that position "because an IRS denial of these applications would adversely affect VA research programs by limiting donations to the corporations" has reportedly gone unanswered.

This Committee, which authored the provisions which became the core of section 204 of P.L. 100–322, made *its* views clear, and they could not escape the notice of any IRS officials seeking to understand the role of a VA research corporation. Such a corporation's acceptance of funding support from a pharmaceutical company for VA-authorized research should play no role in IRS' consideration of an application for tax-exempt status. In requiring that such corporations seek and win recognition as a nonprofit corporation which is exempt from taxes under section 501(c)(3), this Committee was cognizant of and specifically recognized that "[m]any VA researchers are able to obtain support for research which benefits veteran patients from sources other than appropriations made to the Veterans' Administration for medical research. These sources include the NIH, private foundations, and *for-profit companies.*" (Emphasis added.) In developing a measure to facilitate VA's acceptance and use of public *and private* monies for VA-approved research, this Committee certainly will not countenance disregard of the clear intent of that law.

Under existing law, IRS failure to act favorably on five corporations' applications by the end of 1991 will require their dissolution. Fifteen others would be due for dissolution in 1992. Having no assurance that the Internal Revenue Service will act in a timely manner to resolve the dilemma facing the research programs at the medical centers served by these corporations, the Committee in section 306 of the reported bill would extend from three to four years the period within which these corporations must secure tax exempt status. Further, in view of the chilling effect which IRS inaction has had on the establishment of additional research corporations, the bill would also extend by an additional year the "sunset" date for establishing such corporations. Of the 139 VA medical centers which responded to a Central Office survey on the establishment of research corporations as of November 1, 1990, twenty-six medical centers which had not established a corporation expressed

an interest in forming one. An additional year and, what this Committee trusts will be long overdue approval by IRS of pending applications for tax exempt status, should clear the way for many other VA medical centers to establish nonprofit research corporations.

Expansion of Authority to Provide Child Care Services to VA Employees

The Committee received much testimony during the 101st Congress regarding the widespread problems the Department was experiencing with recruitment and retention of health care professionals. In examining policies that would place the VA in a more advantageous position in which to compete for scarce health care professionals, the Committee concluded that a greater use of child care services as a benefit of employment would enhance the VA's efforts in obtaining these needed personnel.

Child care has proven to be an important benefit for VA employees since 1977 when the first center was opened for children of employees at a VA Medical Center (VAMC). Since then VA has established 35 child care centers serving the VA: 12 at VA Regional Offices (VARO), one at the VA Data Processing Center (VADPC), 21 at VAMCs, and one at an outpatient clinic. Of the 22 centers serving VA medical facilities, only one has been established under the Veterans Canteen Service (VCS) authority established in Public Law 100–322.

In virtually every instance, the child care centers currently in operation at VA medical facilities were established under the VA's general out-leasing authority in section 5022(a)(1) of title 38. Under this section, the Department is authorized to lease excess space for not more than three years. When a lease is made under this authority to a public or non-profit organization, part or all of the consideration for the lease may be in the form of maintenance, protection or restoration of the space by the lessee. One major limitation inherent in this authority is the limited time period that the lease may run. Many potential lessees find the maximum lease length of three years to be too short to warrant establishing a child care center under this authority.

In an effort to further encourage the development of child care centers as an employment recruitment incentive, this Committee developed legislation to provide specific authority for VA to establish such centers. That legislation set the foundation for what became section 4209 of title 38 which directs the VA to establish, through the Veterans Canteen Service, child care centers in existing VA facilities where there is an identifiable demand for the services and where it is practicable to provide such care. Under this authority, the VCS Director is responsible for the management and coordination of all matters related to the provision of child care services and must establish reasonable charges for those services. In the case of a VCS-operated center, the child care charges must be sufficient to provide operating costs and in the case of a for-profit center, the charges must take into consideration the value of the space and services furnished to the provider.

Section 4209 also provides that the VA must furnish at no expense space, utilities and custodial services as well as other accommodations for the health and safety of the children. The VCS must reimburse VA facilities for costs associated with the conversion of existing space for use as a day care center. Enrollment in these centers is limited to children of VA employees and, if space is available, to children of other Federal employees. However, to the extent necessary to make it economically feasible to operate the center, section 4209 authorizes VCS to enroll children of employees at affiliated institutions as well as VA research corporations.

In identifying the Veterans Canteen Service as the entity best suited to implement successfully a child-care authority, this Committee relied upon VCS' experience in managing self-sustaining commercial activities and upon its capacity to take on this role. Other factors, however, limited VCS efforts to carry out that role as the Committee had envisioned. VCS' fiscal problems contributed significantly to the failure to effectively implement section 4209. Existing law permits medical centers (or other VA facilities in which centers are established) to convert and renovate space for use as a child care center, but requires VCS to bear that expense. VA's General Counsel concluded that such reimbursement could not be deferred and paid over a period of years. In light of that interpretation and unforeseen financial problems, however, which plagued the Service, the VCS Revolving Fund was determined to have only very limited capital to absorb these substantial start-up costs.

Notwithstanding these operational problems, a hearing conducted by the Subcommittee on Oversight and Investigations and subsequent oversight suggest that the Department itself had little interest at the time in making a VCS-operated child care authority work. The existence of this authority, and the requirement that the Secretary *exercise it* (where there is an identifiable demand for child care and where it is practicable to do so), was for a time seen by some VA officials as diminishing the allure of so-called "enhanced use" authority. (During this period, the Administration had under development and subsequently requested the enactment of authority to establish a pilot program to enter into "enhanced use" leases of VA property. One such "enhanced use" envisioned by VA has been child care centers.)

VA has nevertheless acknowledged the desirability of having a more flexible, specific authority under which to operate, or contract for the operation of, child care centers. Indeed the Department, in its April 10, 1991 testimony before the Subcommittee on Hospitals and Health Care, characterized the proposal under discussion as one which "would provide an additional tool to enable us to meet the need for child care services." The reported bill would do so through a series of refinements, beginning with addition of a new section in chapter 81 of title 38 and repeal of section 4209. New section 5017 would make no reference to the Veterans Canteen Service. The new provision makes clear that this authority is permissive in nature, and does not preclude the Secretary from considering other provisions of law—section 5022(a)(1) (discussed above); 40 U.S.C. sec. 490b (the so-called "Tribble Amendment"); or

such other authority as may become available—as possible bases for establishing child care centers.

The reported bill retains many elements and provisions of existing law, but also takes cognizance of operational issues not previously considered in the development of section 4209. Thus, the bill takes note, for example, of start-up problems which have faced some VA centers. It considers the length of time it may take for a center to build up to full enrollment, whatever the previously identified demand for the service may have been, and the importance of a center becoming not only operationally but *fiscally* viable. Thus, the bill would permit the Secretary to enroll children who have no tie to the VA but only if it is determined necessary to assure the center's financial success. The bill makes clear, however, that members of the public would have lowest priority for enrollment. Thus, enrolling for a year, for example, a child having no other VA tie would afford that child no assurance of re-enrollment in the following year.

The provisions of the reported bill are aimed at giving VA facilities, and their employees, the requisite tools to serve local needs. Like existing law, the measure would authorize centers to be established in surplus space. But the bill recognizes that not all facilities have that resource, and permits needed space to be leased or constructed. As to the operation of a center, the measure retains the flexibility under existing law of permitting VA to operate the center itself or to contract. But the bill contemplates that if a facility were to opt not to provide child care services directly, it would do so under a *service contract*, that is, a contractor to operate the VA's child care center in accordance with VA requirements. The contractor would be selected through a competitive solicitation process. The reported bill also calls for VA to set charges for child care services, but provides VA considerable latitude in doing so. Thus, while the medical center or other facility *must* set charges at a rate calculated to meet staffing expenses or to meet the facility's cost of contracting, as applicable, the bill would authorize fees pegged to a higher level to permit recovery, in whole or in part, of start-up and other expenses. The bill would call for VA to receive those "tuition" payments, although in the event VA contracted for the center's operation, the contract could require the contractor to collect those payments on VA's behalf.

The Committee emphasizes that this measure aims to increase the options available to VA facilities to respond to the needs of their employees. The Committee envisions that the tools provided under this bill as well as other authorities are tools which can be harnessed and managed most effectively at the local facility level. Prior efforts to centralize decisionmaking regarding the establishment of VA child care services contributed to the Department's failure to start up more than a single new center since the enactment of Public Law 100–322 in 1988. While there is certainly benefit to VA's Central Office providing consultative services to assist local facilities in starting new centers, its failure to permit local facilities to make their own choices based on employee preferences, local capabilities, and individual circumstances will likely compromise the effectiveness of this measure, and will certainly frustrate the Committee's intent in making these changes.

Medical Equipment Acquisition and Sharing Program

In 1986, the VA developed an initiative to procure extremely costly, advanced medical technology in conjunction with community institutions which commit to financing 50 percent of the acquisition costs. The program was instituted under congressional urging, but no specific legislation was enacted. Accordingly, VA relied on existing, general statutory authority to mount this initiative.

This joint funding/shared use concept has given VA facilities access to expensive medical equipment which VA might not otherwise be able to justify procuring—both in terms of its cost and workload. Sharing in both cost and usage, however, has provided for greater efficiencies than either partner could have realized on its own. It has provided a means for VA to procure such state of the art equipment as magnetic resonance imaging instrumentation, linear accelerators, lithotripters, and positron emission tomography (PET) scanners. Since the inception of this initiative, the VA procured almost $75 million in equipment at a cost to VA of less than $38 million. Joint funding and shared use of high cost medical equipment—whether therapeutic, diagnostic, or support equipment such as computer systems—appears to be one sound solution for VA which can obviate the need for costly contracting for patient care.

The lack of a specific statutory foundation for this acquisition and sharing program has somewhat limited its effectiveness, however. VA has had to rely on existing authority which has in some instances frustrated efforts to launch meritorious projects. Under its existing authority, VA has had to encourage its facilities to pursue potential opportunities for such joint funding ventures under provisions of law authorizing VA to accept *gifts* to benefit VA patient care. VA officials have thus approached community institutions with proposals that they share in funding the purchase of costly medical equipment but do so as a "donation." Also, VA could not permit such institutions to share title to such equipment under existing authority. Such limitations have discouraged some potential joint venture partners from participating in otherwise mutually beneficial initiatives. In some instances, public institutions, otherwise interested in shared funding and mutual use of certain new technology, have advised VA that they may not donate funds to another public institution. In other instances, potential partners have abandoned otherwise fruitful acquisition initiatives based on a concern that they could not depreciate their share of the cost of equipment. These and other disincentives, which stem from the lack of specific authority, have limited the number of meritorious proposals available for consideration and funding.

The VA acknowledges these problems, and its testimony at the Committee's April 10 hearing expressed unqualified support for legislation to provide specific statutory authority.

Section 308 of the Committee bill would overcome the limitations in existing law which impede a more effective effort at shared funding and mutual use of medical equipment. The bill would allow VA and a community institution to enter into an agreement which would provide for VA to procure, and for the parties to hold joint title to, medical equipment with funds furnished by both par-

ties. VA would be authorized to execute such agreements with any health care facility, medical school or research center (institutions with which VA may enter into mutual use or exchange of use agreements under section 5053 of title 38, U.S. Code). Under the bill, VA may agree to pay not more than half the purchase price of any such equipment. Such agreement must recognize, however, that VA is to procure the equipment. In doing so, VA may pay not more than half the purchase price and may not execute a contract to procure that equipment until the "co-purchaser" provides VA its share of the purchase price. The bill specifically provides that title to such equipment would be held jointly by the United States and the sharing partner.

VA procurement would be carried out in accordance with laws governing Federal acquisition of equipment, except as otherwise specifically provided by the bill. The requirement that VA procure such equipment would enable the Department to assure that its own requirements will be met and would maximize the likelihood that the procurement is the most cost-effective possible. It would both assure that the procurement is a competitive one and permit VA to obtain a better price in instances where it might buy certain equipment in volume through the VA Marketing Center in Hines, IL. This provision of the bill would not, however, authorize a VA facility to purchase a "half interest" in equipment which a community institution has itself procured independently.

Provisions of the bill, aimed at overcoming another disincentive posed under existing law, would authorize VA and its sharing partner to establish an escrow agreement to govern administration of the funds which that institution provides VA as its share of the cost of the equipment purchase. In practice, major medical equipment may not be delivered for a year or even two after execution of an acquisition contract. Under existing law, a sharing partner's payment would yield it no interest for the period those funds are held by VA. The bill would authorize an arrangement under which VA could hold funds in escrow and invest those monies in obligations of the Federal Government or those which are insured by the Government. The provision would allow that institution to earn interest on its payment until delivery of the equipment. The bill clarifies that escrowed funds under this measure will not be considered to be public funds, thereby rendering inapplicable provisions of law governing the use of Government monies. The bill also provides specific authorization to use these "non-public" funds toward the purchase of equipment, thereby rendering inapplicable 31 U.S.C. 1341, which otherwise prohibits an expenditure or obligation exceeding an amount available in an appropriation or fund for that expenditure or obligation.

The reported bill would also provide for the contingency that one partner or the other for extraordinary reasons might need to dispose of its interest in medical equipment procured under a jointly-funded acquisition. It would permit the Department to transfer its interest in such equipment, or, as applicable, to acquire its partner's interest upon a determination that the transfer would be justified by compelling clinical considerations or VA's economic interests.

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The Committee underscores its view that such transfers should not be undertaken lightly, and should be considered only under extraordinary circumstances. In that connection, the bill would call for the Secretary to report to the Committees on Veterans Affairs on the criteria by which determinations on such transfers would be made, as well as on the Secretary's plans for implementing section 308.

At its April 10 hearing on draft legislation, the Committee heard testimony on the benefits which might accrue from enactment of specific authority for joint funding and shared use of medical equipment. Particular reference was made to the utility this concept may have to VA facilities in more rural areas. Nevertheless, with this provision, the Committee simply aims to arm the Department with a more flexible tool than current law affords it. The bill would not limit the Department to equipment purchases of any particular magnitude or attempt to differentiate between "new" or "replacement" equipment purchases. But the Committee does contemplate that the Department will implement the provision in a systematic way, for example, by developing criteria by which to assure that the process of developing, evaluating, and prioritizing proposals for these equipment purchases is closely integrated with pertinent systemwide planning processes to assure sound allocation of resources. The bill's reporting requirement, for example, would specifically call on the Secretary to establish and advise the Committees of such criteria.

Quality Assurance

Section 309 of the reported bill would clarify the nature of the quality assurance programs and activities of the Veterans Health Administration. The measure would state with respect to activities, positions, or programs of the VHA which are wholly or primarily devoted to assuring the quality of VA health care, including the activities of the Office of the Medical Inspector and the Office of the Associate Chief Medical Director for Quality Management, that they are deemed to be an essential part of VA medical care.

TITLE IV—POST-TRAUMATIC STRESS DISORDER

Expansion of Specialized Programs for Care of Post-Traumatic Stress Disorder (PTSD)

Title IV of the reported bill would require the Secretary, subject to a specified level of new funding, to expand in Fiscal Year 1992 the number of specialized Post-Traumatic Stress Disorder (PTSD) treatment sites. The bill would authorize appropriations of $7.4 million in fiscal year 1992 for this purpose. Underscoring as well the important role for research in this area, the measure would require VA to provide dedicated funding support for research on mental illness including PTSD. The bill would also call on the Secretary to make efforts to follow the recommendations of VA's Special Committee on Post-Traumatic Stress Disorder relating to the need for additional inpatient and outpatient PTSD treatment programs. Lastly, the bill would direct the Secretary to prepare a

needs assessment and strategic plan for delivery of PTSD treatment and rehabilitation.

PTSD is an anxiety disorder which clinicians link to a catastrophic or overwhelming event or series of events, such as combat, which can result in an alteration in brain chemistry. VA has in many respects been a leader in treatment, research and education regarding PTSD and recognizes PTSD as a combat-related disorder. VA's treatment experience and research findings contributed to the classification of PTSD in the American Psychiatric Association's Diagnostic and Statistical Manual, 3rd Ed., Revised (DSM-III-R, 1988).

The "National Vietnam Veterans Readjustment Study", mandated in Public Law 98–160 and issued in 1988 provided for the first time a definitive picture of the prevalence of PTSD among Vietnam theater veterans. Carried out between 1984 and 1988, the study found that while the majority of Vietnam veterans have successfully re-entered civilian life, over one third of male Vietnam theater veterans and over one fourth of female Vietnam theater veterans have suffered from symptoms of PTSD at some point after their service. The study also found a relationship between PTSD and other postwar readjustment difficulties. Research findings estimate that the prevalence at any one time of PTSD among male Vietnam theater veterans is 15.2 percent, or 479,000 out of 3.1 million. A significant portion of that population, however, was found not to have used VA mental health services, suggesting a large, unmet clinical need.

Although some medical centers initiated the establishment of specialized units to treat veterans suffering from PTSD, VA in fiscal year 1985 for the first time provided *centralized* funding of $2.6 million for support of inpatient PTSD treatment. In spite of the overall medical care budget remaining essentially static in terms of spending power over the last decade, centralized funding for PTSD treatment has risen significantly; by fiscal year 1991, total funding devoted to specialized PTSD treatment was $27 million. Of that amount, Congress in this and the preceding session appropriated a total of $9 million to expand further VA's capacity to treat PTSD—$5 million in (P.L. 101–507) and $4 million in the Dire Emergency Supplemental (P.L. 102–27).

The funding devoted to PTSD treatment in recent years has helped promote the development of a very substantial specialized capability within the VA. VA has dispersed that capability to reach veterans across the country. The components of this fast-growing national network include specialized inpatient and outpatient treatment regimens, and the formation of specialized, interdisciplinary treatment teams. As funding has become available, VA has selected sites to place new programs, based on factors such as projected workload, geographic equity, and whether local resources are available for support. VA now supports 21 specialized inpatient treatment units (498 beds), 44 PTSD treatment teams, and 4 PTSD/substance abuse inpatient units. The latter were developed exclusively to treat veterans with co-existing PTSD and alcohol or drug abuse problems.

Over the past decade, VA has made substantial progress in providing veterans who suffer from PTSD a continuum of care

through an array of PTSD treatment services. Thus, the level and intensity of care can be closely matched to the individual veteran's symptoms and needs. The spectrum of specialized PTSD services includes the following:

—Vietnam veterans outreach centers (Vet Centers). VA's 194 centers are located in community settings rather than at VA medical centers. They have provided readjustment counseling and services to more than 700,000 veterans and their families. The social workers, psychologists and paraprofessionals assist with readjustment problems in a non-institutional outpatient setting.

—PTSD clinical teams (PCTs). The 44 PTSD Clinical Teams are based at VA medical centers. They comprise a core of three clinicians (including a psychiatrist) and provide direct screening, assessment, and treatment, all on an outpatient basis.

—Specialized inpatient PTSD units (SIPUs). Special inpatient treatment units have existed within VA since 1978. There are now 21 such units in operation nationally. They are staffed by highly trained clinicians and provide intensive inpatient courses of treatment for the veteran whose PTSD is too severe to be treated successfully in other programs.

—PTSD-Substance Use Disorder Units (PSUs). These unique inpatient treatment settings are designed to simultaneously treat veterans with the dual diagnosis of PTSD and substance abuse. VA currently operates 4 of these units.

While VA is known to be a world leader in PTSD research and innovative treatment programs for PTSD, the limitations in current treatment capacity are well documented and evidenced by long waiting lists for admission to many programs. As a result, those with the highest claim to such specialized care, the service-connected veterans, have too often faced long frustrating delays. PTSD, however, is frequently a service-incurred condition. In VA's PTSD Clinical Team programs, for example, 51 percent of Vietnam veterans treated in fiscal year 1990 for PTSD were service-connected for the condition. Its frequent origin in service, and particularly in combat, heighten its priority for funding support.

Consistent with this Committee's recommendations to the House Budget Committee, the Committee recommends that additional funds be devoted to PTSD in fiscal year 1992. Subject to funding, as described in section 107 of the bill, this measure calls for the creation of at least five new specialized inpatient PTSD units, at least ten new PTSD outpatient treatment teams, and at least five new PTSD/substance abuse *outpatient* programs for veterans suffering from PTSD in conjunction with substance abuse. The latter is a relatively new approach designed to treat in an outpatient setting patients with those co-morbidities. An estimated 50–70 percent of Vietnam era veterans with PTSD have stress problems which are complicated by substance abuse and dependency problems.

Expanding the number of specialized treatment sites is intended to help reduce long waits for treatment encountered by service-connected veterans, and to provide services in geographic areas where the need for PTSD treatment can be demonstrated, but no treatment program currently exists. Creation and funding of these new programs would all be contingent under the reported bill on the fiscal year 1992 medical care budget being set at a minimum of at

least $100 million above the President's fiscal year 1992 budget request. The reported bill would authorize the appropriation of $7.4 million for fiscal year 1992, and such sums as necessary for subsequent fiscal years. By its reference to "such sums as necessary" for subsequent years, the Committee intends that phrase to mean $7.4 million as adjusted for inflation. The Committee intends, therefore, that outyear costs would not greatly exceed $7.4 million in any fiscal year.

The bill also would direct the Secretary to attempt to implement those recommendations of the Chief Medical Director's (CMD) Special Committee on PTSD regarding increasing the number of specialized treatment programs. This Committee recognizes the special committee as a group whose expertise makes it a particularly valuable source of guidance to the CMD on how to best meet the needs of veterans with PTSD. At the same time, the Committee is cognizant of the competing priorities for VA funding and the responsibilities of the Secretary and the CMD to meet other veterans' needs. Programs aimed to serve other serious needs such as VA psychiatric care, care of aging veterans, and such basic needs as purchase of needed medical equipment and pharmaceuticals have not only failed to grow but in some instances have been set back by the limitations of VA medical care budgets.

At the same time, this Committee is aware of the competing demands for research funding. In view of the importance of the subject, however, the reported bill calls for VA to assign a priority to, and set a minimum dollar level of, funding for research on mental health, including studies of PTSD, its association with substance abuse, and the treatment of those conditions.

Finally, this Committee sees the need for additional documentation regarding the demand for, and extent of, PTSD treatment services relative to the Department's capacity to provide that care. Thus, VA would be required to identify its potential patient population by estimating the number of veterans with PTSD to whom VA has an *obligation* under applicable provisions of chapter 17, particularly those service-connected for PTSD, and who could be expected to seek care for their condition from VA. In conjunction with carrying out a needs assessment, the reported bill would direct VA to document its plans for addressing the identified need. In this regard, VA should take into account the views of the CMD's Special Committee on PTSD. The Committee believes that developing a needs assessment and strategic plan will encourage VA to formulate a plan for addressing the needs of this important patient population.

Section-by-Section Analysis

Section 101.—Section 101 would amend section 603(a)(1) to authorize fee-basis treatment or contract hospitalization for any disability of a veteran who has a total disability permanent in nature from a service-connected disability.

Section 102(a).—Section 102(a) would amend section 612(b)(1) to authorize the Department of Veterans Affairs (VA) to provide outpatient dental treatment when medically necessary (1) to prepare a

patient for hospital admission or (2) for a veteran receiving VA care or medical services.

Section 102(b).—Section 102(b) would amend section 612(b)(3) to increase from $500 to $1,000 the threshold above which proposed fee-basis dental treatment must be the subject of a second opinion and authorize the Secretary to adjust the threshold if deemed appropriate.

Section 103.—Section 103 would amend section 19011(e)(1) of Public Law 99-272 to extend through fiscal year 1992, the requirement that the Secretary submit a report to the Committees on Veterans Affairs of the House and Senate describing the number of veterans receiving VA health care; the number of veterans who applied for VA health care and did not receive it; and, the reasons why veterans were denied health care.

Section 104.—Section 104 would amend section 617(a)(2) to increase, effective October 1, 1991, the limit on certain grants for home structural alterations for non-service-connected disabled veterans from $600 to $1,200 and for service-connected disabled veterans from $2,500 to $3,300 respectively.

Section 105.—Section 105 would amend section 632(a) to extend, from September 30, 1990 to September 30, 1992, the VA's authority to contract with the Veterans Memorial Medical Center for the care of U. S. veterans in the Philippines.

Section 106(a).—Section 106(a) would, subject to appropriations, as described in section 107 below, require the Secretary to expand the program of outreach and community-based residential care for homeless chronically mentally ill veterans. Such expansion would be carried out by increasing the number of employees who are providing services under that program in geographic areas with the greatest need for such services, and by establishing additional programs in at least four cities in which there is a significant unmet need for assistance for homeless chronically mentally ill veterans. Authorize appropriations for the program of $3.3 million for fiscal year 1992 and such sums as necessary for subsequent fiscal years.

Section 106(b).—Section 106(b) would authorize a pilot program of assistance for homeless veterans to permit the Secretary to enter into agreements with public or nonprofit entities to provide (a) outreach services through the use of vans or other means of transportation, (b) medical and rehabilitative services, and (c) transitional housing. Such services could be provided only if the public or nonprofit entity would provide (directly or by reimbursement to the Secretary) not less than 25 percent of the cost of such services. Any amount received would be credited to the VA medical center through which services would be provided. Section 106(c) authorizes appropriations of $300,000 for the program for fiscal year 1992 and such sums as necessary for subsequent fiscal years.

Section 107.—Section 107 would provide that the Secretary may carry out the new initiatives described in Sections 106(a) and (b) and section 403 only if the amount appropriated for fiscal year 1992 for the medical care account of the VA is not less than $100 million greater than the amount requested for that account in the President's budget for fiscal year 1992.

Section 201.—Section 201 would amend subsection (a) of section 4105 to require that, after the date of enactment, social workers

employed in the Veterans Health Administration hold a master's degree in social work and, if the law of the State of employment so requires, be licensed, certified, or registered, except that the Secretary could waive the latter requirement for up to three years to allow completion of State requirements.

Section 202.—Section 202 would amend section 4312(c)(1) to require that recipients of Health Professional Scholarships serve not less than two years for each year of educational assistance or part thereof.

Section 203.—Section 203 would amend section 4108 to provide that the Secretary may purchase promotional items of nominal value for use in the recruitment of certain health care personnel.

Section 301.—Section 301 would amend paragraph (2) of section 5004(a) to provide that, effective in fiscal year 1993, funds may not be appropriated or expended for any major medical project or new major medical facility lease unless funds for such project have been authorized by law, and reduce from $500 to $300 thousand the threshold of what constitutes a major medical facility lease.

Section 302.—Section 302 would amend subparagraph (C) of section 4101(f)(2) to provide that reports issued by the VA's Geriatrics and Gerontology Advisory Committee will be submitted simultaneously to the Secretary and the appropriate Congressional committees.

Section 303.—Section 303 would establish a pilot program of medical research, subject to appropriations for medical and prosthetic research exceeding the President's fiscal year 1992 request for that account by $43 million. Authorizes appropriations for the pilot program of up to $6 million for research which would be jointly funded by VA and by a medical school or other public or nonprofit institution or agency in the areas of mental illness, alcohol and substance abuse or neurologic, psychiatric and geriatric rehabilitation. In awarding research funding to VA facilities under the pilot program, the Secretary shall give priority to those projects which offer the greatest opportunity for improving the quality of clinical care at the VA facility where the research is to be conducted.

Section 304.—Section 304 would require the Secretary, in consultation with the Secretary of Health and Human Services, to prescribe standards to assure consistent performance by VA laboratories of valid and reliable laboratory examinations and other procedures and provide a report on those standards to the Committees on Veterans' Affairs of the House and Senate describing and explaining the basis for and the differences, if any, between those standards and any standards which the Secretary of Health and Human Services may prescribe to assure consistent performance by laboratories of valid and reliable laboratory examinations under any other provision of law.

Section 305.—Section 305 would amend chapter 1 by adding at the end a new section 115 to authorize the Secretary to acquire and use land for the purposes of the acquisition and operation of VA medical and regional office facilities and national cemeteries prior to Justice Department title approval, and notwithstanding that VA may acquire less than fee simple interest in the property.

Section 306.—Section 306 would (a) amend section 4161(b) to extend, from three to four years, the period within which VA re-

search corporations must secure tax exempt status, and (b) would amend section 4168 to extend by one year the final date for establishment of such corporations.

Section 307.—Section 307 would amend chapter 81 by inserting a new section 5017 to expand the authority to provide child care services and to permit the operation of child care centers through any appropriate office of the Department or through contractual arrangements. It would permit the VA to construct or alter space in any VA facility, or to lease space, for use as a child care center. VA would set charges at a rate sufficient to meet staffing costs but could take into account the costs of establishing the center as well as services it provides a center. Proceeds from charges would be credited to the applicable VA account and allotted to the applicable VA facility and would remain available until expended.

Section 308.—Section 308 would amend chapter 81 by adding new sections Sections 5057 and 5058 to authorize VA and community health care facilities to hold joint title and share in the use of medical equipment under arrangements where VA would pay no more than half the purchase price, the partner would pay monies which VA could hold in escrow and VA would procure the equipment. It would permit VA to sell its interest in such equipment, or buy its partner's interest in exceptional circumstances. The measure would require the VA to report on its plans to implement this authority.

Section 309.—Section 309 would provide that quality assurance programs and activities, pursuant to section 4151(a) or described in section 201(a)(1) and section 201(a)(3) of Public Law 100–322, (including the operations of the VA's Medical Inspector and the Office of Quality Assurance in Central Office) shall be considered part of the provision of VA care, effective October 1, 1991.

Section 401.—Section 401 would cite Title IV as the "Post-Traumatic Stress Disorder Treatment Act of 1991."

Section 402.—Section 402 would make a series of Congressional findings, laying the foundation for the substantive provisions of Title IV.

Section 403.—Section 403 would, subject to appropriations, as described in section 107 above, require, at such locations as the Secretary deems appropriate, the Secretary to establish and operate not less than five new specialized inpatient Post-Traumatic Stress Disorder (PTSD) units, not less than 10 new PTSD clinical treatment teams, and not less than five outpatient programs for treatment of veterans suffering from both PTSD and substance abuse problems. Authorize $7.4 million for fiscal year 1992 and such sums as may be necessary in subsequent fiscal years for these purposes.

Section 404.—Section 404 would require the Secretary, in carrying out research and awarding grants under chapter 73 of title 38, United States Code, to designate a level of funding support and priority to the conduct of research on mental illness including PTSD, PTSD in association with substance abuse and treatment of those disorders.

Section 405.—Section 405 would require the Secretary, in consultation with the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder, to assess the needs for treatment and rehabilitative services of veterans believed to be suffering from PTSD, and to develop a plan for providing needed services.

Section 406.—Section 406 would define the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder to mean the Committee established pursuant to section 110 of Public Law 98–528.

Oversight Findings

No oversight findings have been submitted to the Committee by the Committee on Government Operations.

Congressional Budget Office Cost Estimate

The following letter was received from the Congressional Budget Office on the cost of the reported bill:

U.S. Congress,
Congressional Budget Office,
Washington, DC, May 31, 1991.

Hon. G.V. Montgomery,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for H.R. 2280, the Veterans' Health-Care and Research Amendments of 1991, ordered reported by the House Committee on Veterans' Affairs, May 29, 1991. Because the bill would not affect direct spending, it would have no effect under the pay-as-you-go procedures established by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 and would not require a cost estimate under clause 8 of House Rule XXI.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

Robert D. Reischauer,
Director.

Attachment:

1. Bill number: H.R. 2280.
2. Bill title: Veterans' Health-Care and Research Amendments of 1991.
3. Bill status: As ordered reported by the House Committee on Veterans' Affairs, May 29, 1991.
4. Bill purpose: To expand outpatient dental benefits to veterans, to expand the program of community-based residential care for chronically mentally ill veterans, to authorize a pilot program for the conduct of medical research on a cooperative basis between VA medical centers and medical schools, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Authorization Level	17	18	18	12	14
Estimated Outlays	10	17	18	16	15

Basis of Estimate

The following section-by-section cost analysis addresses only those sections of the bill that could be expected to result in a significant budgetary impact.

Section 102(a). This section would expand eligibility for outpatient dental care to veterans for whom the care is medically necessary in preparation for hospital admission and to veterans who are currently receiving VA medical care.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Estimated Authorization Level	−1	−1	−1	−1	−1
Estimated Outlays	−1	−1	−1	−1	−1

Based on information from the VA, it was estimated that more than $1 million per year is spent on unnecessary inpatient days which are used to provide dental care to veterans who are not eligible for outpatient dental care. An estimated 10,000 veterans a year are admitted to VA hospitals to correct dental conditions that could jeopardize the success of planned medical procedures. Another 5,000 veterans who are in ongoing medical treatment programs receive dental care on an inpatient basis that would be more appropriately provided on an outpatient basis. By granting eligibility for outpatient care to veterans in these limited circumstances, it is estimated that a net savings of more than $800,000 could be realized in 1992.

Section 102 (b). This section would increase from $500 to $1,000 the cost threshold for dental procedures for which a second opinion is required.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Estimated Authorization Level	−1	−1	−1	−1	−1
Estimated Outlays	−1	−1	−1	−1	−1

According to data from the VA, around 9,000 second-opinion exams are performed each year to certify dental procedures costing between $500 and $1,000. The average cost of such exams in 1990 was approximately $100. This amount was increased in subsequent years for anticipated inflation.

Section 104. This section would increase the ceiling on certain grants to disabled veterans for structural alterations in their homes to accommodate their disabilities. The ceiling on such grants for service-disabled veterans would increase from $2,500 to $3,300, and for non-service-disabled veterans from $600 to 1,200.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Estimated Authorization Level	1	1	1	1	2
Estimated Outlays	1	1	1	1	2

The VA anticipates spending $1.7 million in 1991 on home improvement and structural alteration (HISA) grants. Although historical data is not available, VA estimates that 40 percent of such funds will be spent on grants to service-disabled veterans and 60 percent on grants to non-service-disabled veterans. The number and distribution of such grants is assumed to remain relatively unchanged over the next five years. Because virtually all current HISA grants are made at the maximum level, section 104 would be expected to increase spending on service-connected grants by around $200,000 and on non-service-connected grants by about $1.1 million.

Section 106. This section would authorize the appropriation of $3.25 million for the provision of care within the VA to homeless chronically mentally ill veterans. Section 106 would also authorize the appropriation of $0.3 million for a pilot program of cost-sharing agreements with other public or private non-profit organizations for the provision of such care outside the VA. Both authorizations would include such sums as may be necessary for subsequent fiscal years. The funds authorized by section 106 would be in addition to the funds authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (P.L.101–645). The VA would be prohibited from implementing this section if the 1992 appropriation for the Medical Care account is less than $100 million above the amount requested by the President for this account in 1992.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Authorization Level	4	4	4	4	4
Estimated Outlays	3	4	4	4	4

The above estimate assumes that all authorized amounts would be fully appropriated and that outlays would occur according to historical spending patterns for similar activities. The estimate also assumes that the contingency clause tying the implementation of section 106 to the level of the Medical Care appropriation would be fulfilled.

Section 303. This section would authorize appropriations for a pilot program of medical research into certain areas of clinical care. Under the pilot program, VA research projects would be conducted jointly with medical schools, which would provide some funding or in-kind support to partially offset the cost of the research. The VA would be prohibited from implementing this section if the 1992 appropriation for the Medical and Prosthetic Research account is less than $43 million above the amount requested

by the President for this account in 1992. Similar contingencies also apply to implementation in 1993 and 1994.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Authorization Level	6	6	6	0	0
Estimated Outlays	2	5	6	4	1

The above estimate assumes that all authorized amounts would be fully appropriated. Slower than normal spending would be expected in connection with these research projects, because the development of sharing agreements with medical schools would extend the length of the start-up period required by the pilot program.

The estimate also assumes that the contingency clauses tying the implementation of section 303 to the level of the Medical and Prosthetic Research appropriation would be fulfilled.

Section 307. This section would authorize the VA to pay for construction necessary to convert spaces in VA facilities for use as child-care centers.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Estimated Authorization Level	1	1	1	1	1
Estimated Outlays	1	1	1	1	1

This estimate is based on data from the VA concerning the cost and amount of construction work that would be needed to convert space for this purpose. The needed amounts are assumed to be fully appropriated, and outlays are assumed to follow historical spending patterns.

Section 403. This section would require the VA to establish 20 new post-traumatic stress disorder (PTSD) programs in 1992. Five new specialized inpatient units would be required, 10 new PTSD clinical teams, and five outpatient programs for the treatment of veterans suffering from PTSD and substance abuse problems. An appropriation of $7.4 million would be authorized for 1992 and such sums as may be necessary in future years. The VA would be prohibited from implementing this section if the 1992 appropriation for the Medical Care account is less than $100 million above the amount requested by the President for this account in 1992.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996
Authorization Level	7	8	8	8	9
Estimated Outlays	5	8	8	8	9

Based on the Committee's intention as stated in the Committee report on H.R. 2280, the outyear authorization levels were derived by increasing the 1992 level for anticipated inflation. The 1992 outlays are lower than the normal spendout rate would dictate, because the new programs would not be operational for the full year. Outlays in later years are based on historical spending patterns. The estimate assumes that the contingency clause tying the implementation of section 403 to the level of the Medical Care appropriation would be fulfilled.

6. Pay-as-you-go considerations:

The Budget Enforcement Act of 1990 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1995. The bench mark against which changes in direct spending or receipts are measured is the baseline as described in the Act.

None of the provisions of H.R. 2280 would affect direct spending or receipts. Therefore, this bill has no pay-as-you-go implications.

7. Estimated cost to state and local government:

The Congressional Budget Office has determined that the budgets of state and local governments would not be significantly affected by the enactment of this bill.

8. Estimate comparison: None.

9. Previous CBO estimate: None.

10. Estimate prepared by: K. W. Shepherd (226–2820)

11. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

Inflationary Impact Statement

The reported bill will have no inflationary impact.

Department Views

The Committee received the following letter from Department of Veterans Affairs concerning the reported bill:

Department of Veterans Affairs
The Secretary of Veterans Affairs,
Washington, DC, June 5, 1991.

Hon. G.V. Montgomery,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

Dear Mr. Chairman: This will respond to your request for a report on H.R. 2280, 102nd Congress, 1st Session, a bill "[t]o amend title 38, United States Code, to extend and improve veterans' health-care programs."

As discussed in detail below, VA supports some of the provisions of H.R. 2280, and opposes others.

CONTRACT HOSPITAL CARE

Section 101 of the bill would amend 38 U.S.C. Section 603 to authorize VA to contract for the hospitalization of permanently and totally disabled service-connected veterans for any disorder. VA currently has authority to contract for hospital care for these veterans when it is for their service-connected condition. Additional authority to contract for the care of all disabilities is not favored.

VA estimates that the costs associated with enactment of section 101 would be insignificant.

DENTAL BENEFITS

Section 102 of the bill would make two amendments to 38 U.S.C. Section 612(b). VA supports both amendments which are identical to measures the Department submitted to the Congress last year, and which are again in the legislative program for fiscal year 1992.

The first amendment would authorize outpatient dental care to veterans when necessary to prepare them for a hospital admission, or if they are otherwise receiving VA care. Dental work is often necessary to, for example, prepare a veteran for surgery, or other procedures which could be compromised by dental infection. Under existing law, VA can provide most outpatient treatment needed to prepare a patient for hospitalization, but not outpatient dental care. As a result, the Department hospitalizes patients to perform needed dental work which could be performed on an outpatient basis at much less cost.

The second amendment would raise from $500 to $1,000 the threshold at which VA must obtain a second opinion before authorizing fee-basis dental care. Existing law, in effect since 1979, requires a second opinion for procedures over $500, but with the rising cost of medical and dental care, that figure is too low. By raising the ceiling to $1,000 the Department expects to avoid many costly dental reexaminations, saving much more than is saved by the second examinations.

VA estimates that enactment of section 102 would save approximately $1.2 million in fiscal year 1992, and $5.8 million over five fiscal years.

ANNUAL REPORT ON FURNISHING NONSERVICE-CONNECTED CARE

Section 103 of the bill would amend section 19011(e) of the Veterans' Health Care Amendments of 1986, (Public Law 99–272) to continue a requirement first imposed in 1986, that VA submit an annual report to Congress on implementation of the "means test." Section 103 would require a report for fiscal years 1991, and 1992.

VA opposes this section. If Congress needs specific information of the type included in this report, the Department would be pleased to provide it, but an annual reporting requirement of this sort is unnecessary and wasteful.

VA estimates that the costs associated with enactment of section 103 would be insignificant.

HOME IMPROVEMENT AND STRUCTURAL ALTERATIONS BENEFIT INCREASE

Section 104 of the bill would amend 38 U.S.C. Section 617 to increase the maximum amount of the grants VA makes to eligible veterans for home improvements and structural alterations needed to treat the veteran in the home, or for allowing the veteran access to the home or to lavatory facilities. VA does not support an increase in this benefit.

Grants for home improvements are typically used for such things as widening doors and building ramps to allow wheelchair access,

or putting grab bars in a lavatory. The law now provides a maximum lifetime allowance of $600 for nonservice-connected veterans, and $2,500 for service-connected veterans. This provision would increase those amounts to $1,200 and $3,300 respectively, effective on October 1, 1992. VA has no evidence that the current amount of this benefit is insufficient to meet the needs of eligible veterans.

Enactment of section 103 would impose no cost in fiscal year 1992, as it would not be effective in that year, but would cost $4.9 million over five fiscal years.

EXTENSION OF AUTHORITY TO PROVIDE CARE IN THE PHILIPPINES

Section 105 would amend 38 U.S.C. Section 632(a) to extend for one year, the President's authority to enter into contracts with the Veterans Memorial Medical Center (VMMC) in the Philippines. These contracts provide payments for hospital and nursing home care to United States veterans in that hospital. The United States has long recognized an obligation to provide care to Filipino veterans who served in the U.S. Armed Services, and the authority to provide contract care is still needed to fulfill that obligation. Accordingly, VA supports the proposed extension. To avoid having to reauthorize this program every year, however, we recommend that the extension be for a five year period.

VA estimates that enactment of section 103 would cost approximately $500,000 in fiscal year 1992, and $2.5 million over five fiscal years.

PROGRAMS FOR HOMELESS VETERANS

Section 106 would authorize expansion of VA's program for homeless chronically mentally ill veterans, the HCMI Program, and would authorize a small new pilot program under which VA would enter into cooperative agreements with public or nonprofit entities to provide services to homeless veterans. Section 107 of the bill provides that VA may carry out the provisions of section 106 only if Congress appropriates at least $100 million for the VA's medical care account over and above the amount requested in the President's budget for fiscal year 1992. VA opposes sections 106 and 107.

Subsection (a) of section 106 would direct that VA expand the HCMI program by augmenting staff at existing HCMI sites, and by adding new programs in four additional locations with a large unmet need for services. The measure would authorize appropriation of an additional $3.25 million for the program over and above amounts currently authorized.

Subsection (b) of section 106 would authorize a small pilot program under which the Secretary would enter into cooperative arrangements with public or private nonprofit entities to jointly provide services to homeless veterans. The section would authorize the two partners to provide homeless veterans with outreach services using vans or other forms of transportation, medical and rehabilitative services, and transitional housing. Under the program the VA could pay up to 75 percent of the cost of the services, with the other entity paying the remainder. The non-VA partner could provide its share of services for veterans either directly, or by reim-

bursing VA for services the Department provides. if it reimburses VA, any funds received would be credited to accounts available for the particular VA medical facility which provided the services. The bill would authorize appropriation of $300,000 for the pilot program in fiscal year 1992, and any necessary amounts for subsequent years.

VA does not support sections 106 and 107. Rather than mandate expansion of the HCMI program by statute, it would be more appropriate to allow VA to determine, through its normal planning processes, whether additional HCMI sites are warranted, and whether available funds are best used to enlarge existing HCMI programs. Care for homeless veterans has a high priority in VA. It is likely that in any prioritization of programs needing additional funding, homeless programs would fare well. However, VA opposes mandatory provisions of this sort which remove discretion to determine which programs best meet the needs of veterans in general, and homeless veterans specifically.

The pilot program authorized by subsection (b) has a laudable goal which VA certainly supports, but the new authority is unnecessary. Authority already exists to do virtually everything proposed. First, VA can enter into cooperative arrangements with other entities to coordinate provision of services to veterans. Section 220 of title 38, United States Code, directs the Secretary to seek just that sort of coordinated cooperative effort. Moreover, HCMI programs throughout the country now perform outreach on the streets with teams of health-care professionals. Those outreach teams use various means of transportation to bring veterans into the system, and if it is not already being done, they could certainly use vans. Persons brought into the HCMI programs also receive health-care benefits to the extent that they are eligible. Finally, VA is now developing an "independent living housing" program where the Department is purchasing residential homes in which veterans live while participating in compensated work therapy programs. Homeless veterans could certainly be enrolled in compensated work therapy programs, and if it is suitable, could live in one of these therapeutic residences.

VA estimates that enactment of section 106 would cost the amount that the section authorizes, $3.45 million, in fiscal year 1992, and $17.5 million over five fiscal years.

LICENSURE OF SOCIAL WORKERS

Section 201 of the bill would amend 38 U.S.C. Section 4105 to statutorily establish education and licensure qualifications for newly employed VA social workers. The section would direct that all new social workers given a VA appointment hold a Master's Degree in social work, and it would require licensure, certification, or registration if the State where the individual practices requires that. In individual cases, VA could temporarily waive the license, certification or registration requirement to allow the social worker up to three years to complete the State's requirements.

VA strongly supports section 201. Currently 45 States, the District of Columbia, Puerto Rico and the Virgin Islands regulate the practice of social work through licensure, certification or registra-

tion. The Public Health Service has established licensure as a basic requirement for social workers employed by that agency. The Joint Commission on Accreditation of Hospitals, in its hospital accreditation manual, designates current licensure, registration or certification as a "key factor" in the accreditation decision process. Finally, insurance companies and other third party payers require that the care be provided by individuals with appropriate credentials. VA must have qualification requirements that are at least the equal of those prevailing in the health-care community generally.

VA estimates that there would be no costs associated with enactment of section 201.

OBLIGATED SERVICE OF VA SCHOLARSHIP RECIPIENTS

Section 202 would amend 38 U.S.C. Section 4312 to require a minimum two-year service obligation for participants in the VA Health Professional Scholarship Program. VA strongly supports this section.

VA provides scholarships to students studying for various health-care professions. In exchange for assistance, scholarship recipients must agree to work for VA for a specified period.

The service requirement was originally a minimum of two years, but that was changed to one year in 1988. Apparently, it was changed to make the Scholarship Program obligation consistent with the one year obligation in the new Tuition Reimbursement Program.

The principal difficulty with the one-year period of service is that with the time consumed by orientation and on-the-job training, VA is actually assured of receiving only a very short period of effective service. Typically seven to eight months have elapsed before a newly graduated nurse can function independently, and before the Department begins to recoup the full benefit of the scholarship investment. By contrast, the two-year minimum would allow roughly fourteen months of "journeyman" service before a graduate completes his or her employment obligation. The longer period would also help stabilize staffing and reduce turnover.

PURCHASE OF PROMOTIONAL ITEMS FOR RECRUITMENT PURPOSES

Section 203 would amend 38 U.S.C. Section 4108 to authorize VA to purchase small items of nominal value to give to potential recruits. VA opposes this provision. It is not necessary to provide gift items of this nature to meet recruitment needs.

VA estimates that enactment of section 203 would cost approximately $36,000 in fiscal year 1992, and $180,000 over five fiscal years.

MAJOR MEDICAL FACILITY ACQUISITIONS

Section 301 would amend 38 U.S.C. Section 5004(a) to provide that Congress could not appropriate any funds, and VA could not obligate or expend funds, for acquisition of a major medical facility for the VA, or a major medical facility lease or lease renewal, unless funds for the project are specifically authorized by law. The proposal includes an exemption permitting VA to obligate or expend funds for advance planning and design of a project without

funds being specifically authorized. The section would define a major medical facility project as a project costing in excess of $3 million, and a major medical facility lease as any lease exceeding $300,000.

Requiring that major medical facility acquisitions be specifically authorized in law before funds may be appropriated or spent has a laudable goal, which is to assure that scarce funds are used in the most efficient manner. While VA supports that goal, it retains reservations that the measure would, in fact, achieve that goal. The Department is particularly pleased, however, that the section would apply to new leases only, and not to lease renewals, as earlier versions of the legislation proposed. VA is also pleased that the proposal exempts advance planning and design funds from the provisions of the law.

GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE REPORTS

Section 302 would amend 38 U.S.C. Section 4101(f) to require that when the Advisory Committee on Geriatrics and Gerontology submits a report to the Secretary, it must simultaneously submit the report to the Senate and House Veterans Affairs Committees. VA opposes this proposal.

Under current law, reports of the Advisory Committee on Geriatrics and Gerontology are sent to the VA Secretary who in turn transmits a report to the Congressional committees with any comments and recommendations on the Advisory Committee's report. The Geriatrics Advisory Committee, like all such committees, was established to provide advice to the Secretary. When the Committee prepares a report, it should be for the benefit of the Secretary, and after it is reviewed, a report can be sent to the Congress. To require that the report be simultaneously submitted to the Congress would tend to undermine the Secretary's authority, and inhibit his or her ability to accept or reject findings and recommendations of the Committee.

VA estimates that there would be no costs associated with enactment of section 302.

MEDICAL RESEARCH RELATED TO CLINICAL CARE

Section 303 would authorize a three-year pilot program to fund research focused on clinical care in the areas of mental illness, alcohol and substance abuse, and neurologic, psychiatric, and geriatric rehabilitation. VA opposes this section of the bill.

The proposed new pilot program would fund research efforts conducted jointly by a VA medical center and its affiliated medical school, or other institution. The affiliated institution would be required to partially fund the research, or provide in-kind services in support of the research. The proposal specifies that VA establish a peer review process to determine which projects most warrant funding, and priority must be given to those projects that are most likely to improve the quality of clinical care.

Section 303 authorizes appropriation of $6 million for the pilot for each of the three years the program would be authorized. However, it also specifically provides that the Secretary may carry out the program only if the Congress appropriates funds for the VA's

medical and prosthetic research account over and above the amounts requested each year in the President's budget. The additional amounts which must be appropriated each year to trigger the new program are $43 million in fiscal year 1992, $58 million in fiscal year 1993, and $73 million for fiscal year 1994.

Despite the fact that the new program would be implemented only if additional funds are appropriated for the research account, VA opposes enactment of section 303. A mandatory new program of this sort is unnecessary and, like other new mandates in this bill, could hamper the ability of Department officials to effectively manage existing veterans' health-care programs. Precise directives of this type deprive managers of the flexibility needed to provide veterans with the services and programs which best meet their wide ranging, and ever changing needs. If additional funds are forthcoming for VA research, it would be preferable to allocate those funds through the existing competitive process which is integral to VA's existing research program.

As a practical matter, VA already has authority to do everything that this measure would require. The Department can now enter into sharing arrangements with affiliated institutions whereby each party can share specialized medical resources, including research. VA can also establish priorities within the research program to target research toward specific needs. Indeed, the medical research program now does just that, and the President's budget for fiscal year 1992 identified a number of special research initiatives in the very areas that this proposal would target.

VA estimates that enactment of section 303 would cost the amount that the section authorizes, $6 million in each of fiscal years 1992, 1993, and 1994.

STANDARDS FOR VA LABORATORIES

Section 304 would direct the Secretary to prescribe standards for laboratories in VA medical facilities to ensure that those labs produce valid and reliable information. The standards must be established in consultation with the Secretary of Health and Human Services (HHS). The section would also require that when standards are prescribed, the Secretary must submit a report to the Congressional Committees on Veterans Affairs describing any differences between the standards, and any comparable standards promulgated by HHS. The report must also cite the reasons for those differences.

VA officials are currently involved in discussions with officials of the Department of Health and Human Services in order to insure that VA laboratories meet the objectives included in the Clinical Laboratories Improvement Act. Accordingly, we would suggest the Committee defer consideration of section 304 while these discussions proceed.

VA estimates that the cost of enactment of section 304 would be insignificant. Should implementation of the prescribed standards require a change in VA practices, some costs may result.

Acquisition of Real Property.—Section 305 would add a new section 115 to title 38, United States Code, to remove a restriction now in the law which precludes VA from acquiring and using real prop-

erty, or accepting donated real property, before obtaining Department of Justice approval of the title. If section 305 were enacted, the Justice Department would continue to review and approve title for property acquisitions. However, it would allow VA to obtain property more quickly when necessary, and let the technical review process follow. This measure would also authorize the Secretary to acquire property in situations when fee simple title would not vest in the United States. VA supports this section.

Under existing law, before VA can expend funds to acquire real property, or accept a donation of real property, the Attorney General must determine the sufficiency of the title. The Attorney General's authority to examine title has been delegated to other Federal departments and agencies in several instances, but not to the VA. The Department must submit all title documents to the Justice Department for approval. This can slow down the acquisition process. Under this provision, VA would continue to seek Justice Department approval of title, but would be permitted to expend appropriated funds to acquire and use property, or accept donations of property, pending final Justice Department approval.

The section would also permit the Secretary to determine that a lesser than fee simple interest in property might satisfy VA's needs and be sufficient for the purposes of an impending VA project. In some instances, VA may not be able to acquire a fee interest in property on which the Department seeks to construct a facility. With this provision, the Secretary could determine that, for example, a long term lease would provide the VA with sufficient interest in the property to build a permanent facility. This authority will enhance VA's ability to acquire property necessary to serve the needs of veterans.

Extension of Authority to Establish Research Corporations.—Section 306 would amend 38 U.S.C. Section 4168 to extend for one year the authority of VA medical centers to establish independent nonprofit research corporations which serve to assist VA in funding research at the medical centers. It would also amend 38 U.S.C. Section 4161(b) to extend for one year the period during which a newly formed corporation must secure tax exempt status, or be dissolved. VA supports section 306, but recommends that the authority to establish new corporations be extended for five years rather than one year.

The authority to establish research corporations was first granted in 1988. Since then, approximately fifty percent of the VA medical centers with research programs have established corporations. Others remain interested in setting up corporations, but have not yet been able to do so. The corporations are able to accept gifts and grants, and enter into contracts to fund VA research more easily than was formerly the case. Some of the existing corporations have been quite successful in garnering donations which are of great benefit to the research programs. With an extension of the authority, more medical centers will have the opportunity to set up these entities.

VA estimates that there would be no costs associated with enactment of section 306.

CHILD CARE SERVICES

Section 307 would amend title 38, United States Code, by repealing section 4209, which now authorizes provision of child care services through the Veterans Canteen Service, and by adding a new section 5017 to more clearly authorize VA to provide such services. VA supports this section which would provide the Department with a workable tool for establishing needed child care centers.

Provision of child care services in the work place has long been recognized as an excellent tool for recruiting and retaining employees. But more importantly, it is needed for the well-being of employees who are working parents. Child care centers exist in some VA medical centers, but in many other locations, the resources (both human and financial) are not available to create centers under existing legal authority. Section 4209, the authority for the Canteen Service to establish and operate child care centers, is limited and has not served the Department well. This new section would meet the VA's needs.

Section 307 would permit VA to provide for the operation of child care centers either directly (VA would hire caregivers, for example) or through service contracts. Priority for services would be given to VA employees, followed by other Federal employees, and employees of affiliated schools. A center could also serve members of the general public to the extent there is space available in a particular center, but only if the Secretary determines that serving the public is necessary to assure the financial success of the center. VA would establish charges for child care which would be sufficient to meet all staffing costs. The Department could establish centers in surplus space, and if that is not available, obtain space through construction or leasing. VA could also provide for other services and amenities such as utilities and furnishings on an ongoing basis.

VA estimates that enactment of section 307 would result in costs for renovations of space for child care centers of $1.5 million in fiscal year 1992, and $7.5 million over five fiscal years.

ACQUISITION AND SHARING OF ADVANCED MEDICAL TECHNOLOGY

Section 308 would add a new section 5057, and a section 5058 to title 38, to clarify the authority for, and greatly enhance VA's program for allowing medical centers to acquire and share advanced medical technology jointly with other institutions in the community. For several years VA has been acquiring highly sophisticated and expensive medical equipment in conjunction with other health-care entities, usually affiliated institutions. Acquisition costs are shared, and the resource itself is shared. However, the existing legal authority to undertake these joint ventures is somewhat convoluted, and not conducive to easily accomplishing the desired goal. VA strongly supports this section which would rectify those problems.

Under the existing program, VA must acquire and hold title to any equipment purchased, and then share the equipment with the other health-care entity pursuant to a sharing agreement. To assist with the initial acquisition costs, the sharing partner must make a donation to the VA which is then used f or the purchase. Problems

have arisen because many potential sharing partners are unwilling to pay part of the cost of equipment without being allowed to share title. Others, particularly public institutions, cannot "donate" funds to another public institution such as the VA. Some potential partners want to depreciate their portion of the equipment for which they "paid." Also, it often takes a long period of time for equipment to be delivered after an order is placed. If a sharing partner has made a donation toward that purchase, the money lies idle, without earning any interest, until the equipment is actually received. We would strongly urge that the escrow agent be the Secretary of the Treasury. This would be consistent with other escrow funds in Federal programs, which are in the Treasury Department. We also believe that the bill as drafted would create contract authority within the medical care program by allowing the Secretary to purchase equipment when only half of the funds to cover the purchase are available for obligation. We would like to work with the Committee to examine alternatives that would not require another resource authority in medical care.

Section 308 attempts to rectify all of these problems. it would permit VA and the sharing partner to agree to hold title jointly, encouraging more institutions to compete for participation, and allowing VA the luxury of choosing from more and potentially better proposals. It would permit the Department to transfer its interest in the equipment to the sharing partner if that is in VA's interest, and it would require the sharing partner to pay one-half the depreciated purchase price of the equipment if it wanted to obtain VA's interest in it.

QUALITY ASSURANCE ACTIVITIES

Section 309 would clarify that health-care quality assurance activities which are conducted in support of VA health-care facilities, are a part of the operation of those facilities, even when the workplace of employees performing quality assurance functions is not at a health-care facility. VA supports this section.

Medical quality assurance activities in the VA are unique in that they are undertaken in direct support of individual VA medical facilities, but are often best administered centrally for reasons of economy, and to foster systemwide uniformity. The clarifying language of section 309 will effectively allow VA to avoid having to place all of the various quality assurance activities in individual medical centers. It will permit the funding of such quality assurance activities as a proposed new contract external peer review program, a proposed new quality assurance facility inspections program, and a Quality Management Institute. Without the provision, the Department's ability to establish and implement uniform quality standards will be limited. This section recognizes the close and important connection that exists between effective quality assurance programs and providing the highest quality direct medical care.

POST-TRAUMATIC STRESS DISORDER

Title IV of the bill contains six sections (sections 401–406) which together constitute the "Post-Traumatic Stress Disorder Treatment

Act of 1991." Substantively, the Act would (1) direct expansion of VA specialized programs for the treatment of PTSD, (2) direct that the Secretary give a priority to funding of research on mental illness, including PTSD, and (3) direct that the Secretary assess the needs for treatment and rehabilitative services for veterans with PTSD, and develop a plan to meet those needs. VA opposes title IV of the bill.

Section 401 simply cites the title of the Act, and section 402 lists a series of nine Congressional findings pertaining to PTSD among veterans, and VA's ability (or lack thereof) to provide adequate treatment for the disorder.

Section 403 contains two substantive provisions. First, subsection (a) would direct the Secretary to seek to implement the recommendations of the CMD's Special Committee on PTSD regarding expansion of specialized inpatient and outpatient programs for treating PTSD. (Section 406 of the bill defines the Special Committee as that which was established pursuant to section 110 of Public Law 98-528.) Second, subsection (b) of section 403 would require the Secretary, during fiscal year 1992, to establish and operate at least five new specialized inpatient PTSD units (SIPU's), ten new PTSD clinical treatment teams (PCT's), and five new outpatient programs for veterans with both PTSD and a substance abuse problem. Those programs are commonly referred to as PTSD/Substance use Disorder Programs (PSU's). The bill authorizes appropriation of $7.4 million in fiscal year 1992 to carry out the expansion of the PTSD programs, and such sums as are necessary in subsequent years. However, subsection (b) is made subject to section 107 of the bill, which provides that VA may carry out subsection (b)only if Congress appropriates at least $100 million for the VA's medical care account over and above the amount requested in the President's budget for fiscal year 1992.

Section 404 would direct the Secretary to designate a specific level of funding support for research on mental illness, including research on PTSD, research on PTSD in association with substance abuse, and research on treating those disorders. The section directs the Chief Medical Director to establish procedures for distributing the research funds. The Secretary would have to submit a report on implementation of the section to the Congressional Committees on Veterans Affairs by December 1, 1992.

Section 405 would direct the Secretary to assess the treatment and rehabilitative needs of veterans with PTSD, and develop a plan for meeting those needs, and for expanding and refining VA services for treating PTSD. The assessment and planning must be conducted in consultation with the CMD's Special Committee on PTSD, and a report on the plan must be sent to the Congressional Committees on Veterans Affairs by August 30, 1992.

VA continues to oppose this major effort to direct the specific actions it must take to provide needed benefits to veterans. The Department agrees that additional inpatient and outpatient programs are needed to care for those suffering from post-traumatic stress disorder, and new programs will be forthcoming. However, legislation directing the precise actions that the Department must take to meet the needs of those with PTSD, is unnecessary and objectionable. if additional sums are appropriated for health-care benefits

for veterans, it is highly likely that programs for treating veterans with PTSD will be expanded. Nevertheless, other worthy and needed programs should be able to compete for the additional funds. VA officials are striving to meet the many health-care needs of all veterans, and when specific programs are mandated, as would be the case with this proposal, those officials lose their flexibility to meet other needs which may have an even higher priority than the programs for PTSD.

VA estimates that title IV of the bill would cost $7.6 million in fiscal year 1992, and $37.2 million over five fiscal years.

The office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on H.R. 2280 to the Congress.

Sincerely,

EDWARD J. DERWINSKI,

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

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PART I—GENERAL PROVISIONS

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CHAPTER 1—GENERAL

Sec.
101. Definitions.

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115. Acquisition of real property.

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§ 115. Acquisition of real property

For the purposes of sections 230 and 1006 of this title and subchapter I of chapter 81 of this title, the Secretary may acquire and use real property—

(1) before title to the property is approved under section 355 of the Revised Statutes (40 U.S.C. 255); and

(2) even though the property will be held in other than a fee simple interest in a case in which the Secretary determines that the interest to be acquired is sufficient for the purposes of the intended use.

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER I—GENERAL

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§ 603. Contracts for hospital care and medical services in non-Veterans' Administration facilities

(a) When Veterans' Administration facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Administrator, as authorized in section 610 or 612 of this title, may contract with non-Veterans' Administration facilities in order to furnish any of the following:

(1) Hospital care or medical services to a veteran for the treatment of—

(A) a service-connected disability; [or]

(B) a disability for which a veteran was discharged or released from the active military, naval, or air service[.]; *or*

(C) [*for*] *any disability of a veteran who has a total disability permanent in nature from a service-connected disability.*

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SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

* * * * * * *

§ 612. Eligibility for outpatient services

(a) * * *

(b)(1) Outpatient dental services and treatment, and related dental appliances, shall be furnished under this section only for a dental condition or disability—

(A) * * *

* * * * * * *

(F) from which a veteran who is a former prisoner of war and who was detained or interned for a period of not less than 90 days is suffering; [or]

(G) from which a veteran who has a service-connected disability rated as total is suffering[.]; *or*

(H) which is medically necessary (i) in preparation for hospital admission, or (ii) for a veteran otherwise receiving care or services under this chapter.

* * * * * * *

(3) The total amount which the Administrator may expend for furnishings, during any twelve-month period, outpatient dental services, treatment, or related dental appliances to a veteran under this section through private facilities for which the Administrator has contracted under clause (1), (2), or (5) of section 603(a) of this title may not exceed [$500] *$1,000* unless the Administrator determines, prior to the furnishing of such services, treatment, or appliances and based on an examination of the veteran by a dentist employed by the Veterans' Administration (or, in an area where no such dentist is available, by a dentist conducting such examination under a contract or fee arrangement), that the furnishing of such services, treatment, or appliances at such cost is reasonably necessary. *The Secretary may periodically review the cost of dental care to determine whether the dollar ceiling contained in this paragraph remains appropriate to carry out the purposes of this paragraph. Based upon such review, the Secretary may, from time to time, adjust that ceiling in such amount as the Secretary determines necessary.*

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§ 617. Home health services; invalid lifts and other devices

(a)(1) * * *

(2) Improvements and structural alterations may be furnished as part of such home health services only as necessary to assure the continuation of treatment for the veteran's disability or to provide access to the home or to essential lavatory and sanitary facilities. The cost of such improvements and structural alterations (or the amount of reimbursement therefor) under this subsection may not exceed—

(A) [$2,500] *$3,300* in the case of medical services furnished under paragraph (1) of section 612(a) of this title; or

(B) [$600] *$1,200* in the case of medical services furnished under any other provision of section 612 of this title.

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SUBCHAPTER IV—HOSPITAL CARE AND MEDICAL TREATMENT FOR VETERANS IN THE REPUBLIC OF THE PHILIPPINES

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§ 632. Contracts and grants to provide for the care and treatment of United States veterans by the Veterans Memorial Medical Center

(a) The President, with the concurrence of the Republic of the Philippines, may authorize the Administrator to enter into contracts with the Veterans Memorial Medical Center, with the approval of the appropriate department of the Government of the Republic of the Philippines, covering the period beginning on October 1, 1981, and ending on September 30, [1990] *1992*, under which the United States—

(1) * * *

* * * * * * *

PART V—BOARDS AND DEPARTMENTS

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CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

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SUBCHAPTER I—ORGANIZATION; GENERAL

§ 4101. Functions of Department

(a) * * *

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(f)(1) * * *

(2)(A) * * *

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[(C)(i) Not later than April 1, 1983, the Committee shall submit to the Administrator, through the Chief Medical Director, a report with respect to its findings and conclusions under subparagraph (B) of this paragraph. Such report shall include—

[(I) descriptions of the operations of the centers of geriatric research, education, and clinical activities established pursuant to paragraph (1) of this subsection;

[(II) assessments of the quality of the operations of such centers;

[(III) an assessment of the extent to which the Veterans' Administration, through the operation of such centers and other health-care facilities and programs, is meeting the needs of eligible older veterans for geriatric and extended-care and other health-care services;

[(IV) assessments of and recommendations for correcting any deficiencies in the operations of such centers; and

(V) recommendations for such other geriatric, extended-care, and other health-care services as may be needed to meet the needs of older veterans.

Following the submission of such report, the Committee shall also submit to the Administrator, through the Chief Medical Director, such further reports as the Committee considers appropriate with respect to the matters described in clauses (I) through (V) of the preceding sentence.

[(ii) Not later than ninety days after receipt of a report submitted under division (i) of this subparagraph, the Administrator shall transmit such report, together with the Administrator's comments and recommendations thereon, to the appropriate committees of the Congress.]

(C)(i) The Committee shall submit to the Secretary, through the Chief Medical Director, such reports as the Committee considers appropriate with respect to its findings and conclusions under sub-

paragraph (B) of this paragraph. Such reports shall include the following:

(I) Descriptions of the operations of the centers of geriatric research, education, and clinical activities established pursuant to paragraph (1) of this subsection.

(II) Assessments of the quality of the operations of such centers.

(III) An assessment of the extent to which the Department, through the operation of such centers and other health-care facilities and programs, is meeting the needs of eligible older veterans for geriatric and extended-care and other health-care services.

(IV) Assessments of, and recommendations for correcting any deficiencies in, the operations of such centers.

(V) Recommendations for such other geriatric, extended-care, and other health-care services as may be needed to meet the needs of older veterans.

(ii) Whenever the Committee submits a report to the Secretary under division (i) of this subparagraph, the Committee shall at the same time transmit a copy of the report in the same form to the appropriate committees of Congress. Not later than 90 days after receipt of a report under division (i) of this subparagraph, the Secretary shall submit to the appropriate committees of Congress a report containing any comments and recommendations of the Secretary with respect to the report of the Committee.

§ 4105. Qualifications of appointees

(a) Any person to be eligible for appointment to the following positions in the Department of Medicine and Surgery must have the applicable qualifications:

(1) * * *

* * * * * * *

(10) SOCIAL WORKER.—Hold a master's degree in social work from a college or university approved by the Secretary and, if the law of the State of employment so requires, be licensed, certified, or registered as a social worker, except that to allow completion of requirements for such licensure, certification, or registration, the Secretary may waive the requirement in any case for a period not to exceed three years.

* * * * * * *

§ 4108. Personnel administration

(a) * * *

* * * * * * *

(f) The Secretary may purchase promotional items of nominal value for use in the recruitment of individuals for employment under this chapter. The Secretary shall prescribe guidelines for the administration of the preceding sentence.

* * * * * * *

SUBCHAPTER VI—RESEARCH CORPORATIONS

§ 4161. Authority to establish; status

(a) * * *

(b) If by the end of the [three-year] *four-year* period beginning on the date of the establishment of a corporation under this subchapter the corporation is not recognized as an entity the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, the Administrator shall dissolve the corporation.

* * * * * * *

§ 4168. Expiration of authority

No corporation may be established under this subchapter after September 30, [1991] *1992*.

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CHAPTER 75—VETERANS' CANTEEN SERVICE

Sec.
4201. Purpose of Veterans' Canteen Service.

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[4209. Child-care centers.]

* * * * * * *

[§ 4209. Child-care centers

[(a)(1) The Administrator, through the Service, shall provide for the operation of child care centers at Veterans' Administration facilities in accordance with this section. The operation of such centers shall be carried out to the extent that the Administrator determines, based on the demand for the care involved, that such operation is in the best interest of the Veterans' Administration and that is practicable to do so. The centers shall be available for the children of Veterans' Administration employees and, to the extent space is available, the children of other employees of the Federal Government and the children of employees of affiliated schools and corporations created under section 4161 of this title.

[(2) There shall be in the Service an official who is responsible for all matters relating to the provision of child care services under the authority of this section.

[(b) The Service shall establish reasonable charges for child-care services provided at each child-care center operated under this section. The charges shall be subject to the approval of the Administrator. In the case of a center operated directly by the Service, the charges with respect to the center shall be sufficient to provide for the operating expenses of the center, including the expenses of personnel assigned to the center. In the case of a center operated by a contractor which is a for-profit entity, the charges shall be established by taking into consideration the value of the space and services furnished with respect to the center under subsection (c)(1) of this section.

[(c) In connection with the establishment and operation of any child care center under this section, the Administrator—

[(1) shall furnish, at no cost to the center, space in existing Veterans' Administration facilities and utilities, custodial services, and other services and amenities necessary (as determined by the Administrator) for the health and safety of the children provided care at the center;

[(2) may, on a reimbursable basis, convert space furnished under clause (1) of this subsection for use as the child care center and provide other items necessary for the operation of the center, including furniture, office machines and equipment, and telephone service, except that the Administrator may furnish basic telephone service and surplus furniture and equipment without reimbursement;

[(3) shall provide for the participation (directly or through a parent advisory committee) of parents of children receiving care in the center in the establishment of policies to govern the operation of the center and in the oversight of the implementation of such policies.

[(4) shall require the development and use of a process for determining the fitness and suitability of prospective employees of or volunteers at the center; and

[(5) shall require in connection with the operation of the center compliance with all State and local laws, ordinances, and regulations relating to health and safety and the operation of child-care centers.

[(d) The Administrator shall prescribe regulations to carry out this section.

[(e) For the purpose of this section, the term "parent advisory committee" means a committee comprised of, and selected by, the parents of children receiving care in a child care center operated under this section.]

* * * * * * *

CHAPTER 76—HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

* * * * * * *

SUBCHAPTER II—SCHOLARSHIP PROGRAM

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§ 4312. Eligibility; application; agreement

(a)(1) * * *

* * * * * * *

(c)(1) An agreement between the Administrator and a participant in the Scholarship Program shall (in addition to the requirements set forth in section 4304 of this title) include the following:

(A) * * *

(B) The participant's agreement to serve as a full-time employee in the Department of Medicine and Surgery for a period of time (hereinafter in this subchapter referred to as the "period of obligated service") of one calendar year for each

school year or part thereof for which the participant was provided a scholarship under the Scholarship Program[.], *but for not less than two years.*

* * * * * * *

PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

* * * * * * *

CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

Sec.
5001. Definitions.

* * * * * * *

5017. Child care centers.

* * * * * * *

SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

5051. Statement of congressional purpose.

* * * * * * *

5057. Joint title to medical equipment.
5058. Deposit in escrow.

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

* * * * * * *

§ 5004. Congressional approval of certain medical facility acquisitions

(a)(1) * * *

[(2) It shall not be in order in the Senate or in the House of Representatives to consider a bill, resolution, or amendment which would make an appropriation for any fiscal year which may be expended for a major medical facility project or a major medical facility lease unless—

[(A) such bill, resolution, or amendment specifies the amount to be appropriated for that project or lease,

[(B) the project or lease has been approved in a resolution adopted by the Committee on Veterans' Affairs of that House, and

[(C) the amount to be appropriated for that project or lease is no more than the amount specified in that resolution for that project or lease for that fiscal year.]

(2) No funds may be appropriated for any fiscal year, and the Secretary may not obligate or expend funds (other than for advance planning and design), for any major medical project or any major medical facility lease unless funds for that project or lease have been specifically authorized by law.

(3) For the purpose of this subsection:

(A) * * *

(B) The term "major medical facility lease" means a lease for space for use as a *new* medical facility at an average annual rental of more than [$500,000] *$300,000.*

* * * * * * *

(c) Not less than 30 days before obligating funds for a major medical facility project approved by a [resolution] *law* described in subsection (a)(2) of this section in an amount that would cause the total amount obligated for that project to exceed the amount specified in the [resolution] *law* for that project (or would add to total obligations exceeding such specified amount) by more than 10 percent, the Administrator shall provide the Committees with notice of the Administrator's intention to do so and the reasons for the specified amount being exceeded.

* * * * * * *

§ 5017. Child care centers

(a) The Secretary may provide for the operation of child care centers at Department facilities in accordance with this section. The operation of such centers shall be carried out to the extent that the Secretary determines, based on the demand by employees of the Department for the care involved, that such operation is in the best interest of the Department and that it is practicable to do so. In offering child care services under this section, the Secretary shall give priority, in the following order, to employees of (1) the Department of Veterans Affairs, (2) other departments and agencies of the Federal Government, and (3) affiliated schools and corporations created under section 4161 of this title. To the extent space is available, the Secretary may provide child care services to members of the public if the Secretary determines that to do so is necessary to assure the financial success of such center.

(b)(1) The Secretary shall establish reasonable charges for child care services provided at each child care center operated under this section.

(2) In establishing charges at a center, the Secretary shall ensure that the sum of all charges for child care services is sufficient to meet the staffing expenses of the child care center and may consider the expenses of constructing or acquiring space for the center, the expenses of converting existing space into the center, and the expenses of equipment and services furnished to the center under subsection (c)(2) of this section.

(3) Proceeds from charges for child care services shall be credited to the applicable Department of Veterans Affairs account and shall be alloted toi the facility served by the child care center and shall remain available until expended.

(c) In connection with the establishment and operation of a child care center under this section, the Secretary—

(1) may construct or alter space in any Department facility, and may lease space in a non-Department facility for a term not to exceed 20 years, for use as a child care center;

(2) may provide, out of operating funds, other items and services necessary for the operation of the center, including furniture, office machines and equipment, utility and custodial services, and other necessary services and amenities;

(3) shall provide for the participation (directly or through a parent advisory committee) of parents of children receiving care in the center in the establishment of policies to govern the operation of the center and in the oversight of the implementation of such policies;

(4) shall require the development and use of a process for determining the fitness and suitability of prospective employees of or volunteers at the center; and

(5) shall require in connection with the operation of the center compliance with all State and local laws, ordinances, and regulations relating to health and safety and the operation of child care centers.

(d) The Secretary shall prescribe guidelines to carry out this section.

(e) For the purpose of this section, the term "parent advisory committee" means a committee comprised of, and selected by, the parents of children receiving care in a child care center operated under this section.

* * * * * * *

SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

* * * * * * *

§ 5057. Joint title to medical equipment

(a) Subject to subsection (b), the Secretary may enter into agreements with institutions described in section 5053(a) of this title for the joint acquisition of medical equipment.

(b)(1) The Secretary may not pay more than one-half of the purchase price of equipment acquired through an agreement under subsection (a).

(2) Any equipment to be procured under such an agreement shall be procured by the Secretary. Title to such equipment shall be held jointly by the United States and the institution.

(3) Before equipment acquired under such an agreement may be used, the parties to the agreement shall arrange by contract under section 5053 of this title for the exchange of use of the equipment.

(4) The Secretary may not contract for the acquisition of medical equipment to be jointly purchased under an agreement under subsection (a) until the institution which enters into the agreement provides to the Secretary its share of the purchase price of the medical equipment.

(c)(1) Notwithstanding any other provision of law, the Secretary may transfer the interest of the Department of Veterans Affairs in equipment acquired through an agreement under subsection (a) to the institution which holds joint title to the equipment if the Secretary determines that the transfer would be justified by compelling clinical considerations or the economic interest of the Department. Any such transfer may only be made upon agreement by the institu-

tion to pay to the Department the amount equal to one-half of the depreciated purchase price of the equipment. Any such payment when received shall be credited to the applicable Department medical appropriation.

(2) Notwithstanding any other provision of law, the Secretary may acquire the interest of an institution in equipment acquired under subsection (a) if the Secretary determines that the acquisition would be justified by compelling clinical considerations or the economic interests of the Department of Veterans Affairs. The Department of Veterans Affairs may not pay more than one-half the depreciated purchase price of the equipment.

§ 5058. Deposit in escrow

(a) To facilitate the procurement of medical equipment pursuant to section 5057 of this title, the Secretary may enter into escrow agreements with institutions described in section 5053(a) of this title. Any such agreement shall provide that—

(1) the institutions shall pay to the Secretary the funds necessary to make a payment under section 5057(b)(4) of this title;

(2) the Secretary, as escrow agent, shall administer those funds in an escrow account;

(3) the Secretary shall disburse the escrowed funds to pay for such equipment upon its delivery or in accordance with the contract to procure the equipment and shall disburse all accrued interest or other earnings on the escrowed funds to the institution.

(b) As escrow agent for funds placed in escrow pursuant to an agreement under subsection (a), the Secretary may—

(1) invest the escrowed funds in obligations of the Federal Government or obligations which are insured or guaranteed by the Federal Government;

(2) retain in the escrow account interest or other earnings on such investments;

(3) disburse the funds pursuant to the escrow agreement; and

(4) return undisbursed funds to the institution.

(c)(1) If the Secretary enters into an escrow agreement under this section, the Secretary may enter into an agreement to procure medical equipment if one-half the purchase price of the equipment is available in an appropriation or fund for the expenditure or obligation.

(2) Funds held in an escrow account under this section shall not be considered to be public funds.

* * * * * * *

SECTION 19011 OF THE

VETERANS' HEALTH CARE AMENDMENTS OF 1986

SEC. 19011. ELIGIBILITY FOR HEALTH CARE OF VETERANS WITH NON-SERVICE-CONNECTED DISABILITIES.

(a) * * *

* * * * * * *

(e) REPORTS ON FURNISHING OF HEALTH CARE AND IMPLEMENTATION OF CHANGES IN ELIGIBILITY.—(1) The Administrator of Veterans' Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the House of Representatives a report for [each of fiscal years 1986, 1987, 1988 and 1989] *each fiscal year through fiscal year 1992* concerning the implementation of the amendments made by this section.

SECTION 115 OF THE

VETERANS' BENEFITS AND SERVICES ACT OF 1988

SEC. 115. PILOT PROGRAM OF COMMUNITY-BASED RESIDENTAL CARE FOR HOMELESS CHRONICALLY MENTALLY ILL AND OTHER VETERANS.

(a) AUTHORITY FOR PROGRAM.—(1) The [Administrator] *Secretary of Veterans Affairs* shall conduct a pilot program to provide care and treatment and rehabilitative services (directly or by contract) in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities to homeless veterans suffering from chronic mental illness disabilities who are eligible for care under section 610(a)(1) of title 38, United States Code.

(2) As part of the pilot program, the [Administrator] *Secretary* may also provide such care and treatment and rehabilitative services—

(A) to veterans being furnished hospital or nursing home care by the [Administrator] *Secretary* for a chronic mental illness disability; and

(B) to veterans with service-connected chronic mental illness disabilities.

(b) CRITERIA FOR FACILITIES.—Before furnishing care and treatment and rehabilitative services by contract under subsection (a) to a veteran through a facility described in subsection (a), the [Administrator] *Secretary* shall approve (in accordance with criteria which the [Administrator] *Secretary* shall prescribe) the quality and effectiveness of the program operated by such facility for the purpose for which such veteran is to be furnished such care and services.

(c) IN-KIND ASSISTANCE.—The [Administrator] *Secretary* may provide in-kind assistance (through the services of [Veterans' Administration] *Department of Veterans Affairs* employees and the sharing of other [Veterans' Administration] *Department* resources) to a facility described in subsection (a) under this section. Any such in-kind assistance shall be provided under a contract between the [Veterans' Administration] *Department* and the contract facility. The [Administrator] *Secretary* may provide such assistance only for use solely in the furnishing of appropriate care and services under this section and only if, under such contract, the [Veterans' Administration] *Department* receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the

charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the [Veterans' Administration] *Department* facility that provided the assistance.

(d) DURATION OF PROGRAM.—The authority for the pilot program authorized by this section expires on September 30, 1989.

(e) REPORT.—Not later than February 1, 1989, the [Administrator] *Secretary* shall submit to the Committee on Veterans' Affairs of the Senate and House of Representatives a report on the experience of the Veterans' Administration under the pilot program through September 30, 1988, and the recommendation of the [Administrator] *Secretary* (together with the reasons for such recommendation) as to whether the pilot program should be continued.

* * * * * * *

APPENDIX

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U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515

June 24, 1991

The Honorable G. V. Montgomery
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Pursuant to our agreement of the past week to revise Section 304 of H.R. 2280 as ordered reported, the Committee on Energy and Commerce will not seek a sequential referral of H.R. 2280. This determination does not constitute a waiver of any jurisdiction which this Committee may have over the subject matter in question.

As you know, following Committee consideration of H.R. 2280, the Committee on Energy and Commerce, which under Rule X of the Rules of the House of Representatives has jurisdiction over public health, health and health facilities, expressed jurisdictional and substantive objections to the section as ordered reported.

As a result of the discussions between the two Committees, the Committees agreed to a modified version of Section 304. The modified version assures the application of the standards required by Section 353(f) of the nation's laboratories, including Veterans laboratories. It also recognizes the desirability of vesting the Secretary of Veterans' Affairs with authority for applying those requirements to Veterans laboratories by requiring the Secretary to prescribe regulations in accordance with the requirements of Section 353(f) and to establish appropriate compliance measures.

The Committees have agreed that this modified version will be included as an amendment to the bill as ordered reported in a vehicle to be considered under suspension of the House rules. In light of the Committees' ability to work together in fashioning this revised language, the Committee on Energy and Commerce agrees not to seek a sequential referral of the bill.

I understand that you have agreed to include this letter reflecting the substance of our agreement in the report to accompany H.R. 2380.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

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June 24, 1991

Honorable John Dingell
Chairman
Committee on Energy and Commerce
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter of June 24, 1991, regarding H.R. 2280. Your letter accurately reflects our discussions and agreement of the past week.

I will be happy to include your letter in the report to accompany H.R. 2280.

Sincerely,

Sonny

G. V. (SONNY) MONTGOMERY
Chairman

GVM:cls

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